

106TH CONGRESS
2D SESSION

H. R. 5324

To amend the Social Security Act to make corrections and refinements in the Medicare, Medicaid, and SCHIP health insurance programs, as revised by the Balanced Budget Act of 1997 and the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 27, 2000

Mr. MARKEY (for himself, Mr. FRANK of Massachusetts, Mr. MOAKLEY, Mr. NEAL of Massachusetts, Mr. MEEHAN, Mr. OLVER, Mr. TIERNEY, Mr. DELAHUNT, Mr. MCGOVERN, Mr. CAPUANO, Ms. MILLENDER-MCDONALD, Mr. DOYLE, Mr. BLUMENAUER, Mr. HILLIARD, Mr. ABERCROMBIE, Mr. MASCARA, Mr. PAYNE, Mr. ROMERO-BARCELO, Ms. LEE, Mr. CONYERS, Mr. SANDERS, Mr. CLEMENT, Ms. MCKINNEY, Mr. BLAGOJEVICH, Mr. BARCIA, Mr. DAVIS of Illinois, Mr. HINOJOSA, Mrs. MEEK of Florida, Mr. SANDLIN, Ms. BROWN of Florida, Ms. KILPATRICK, Mr. PICKETT, Ms. WATERS, Mr. REYES, Mrs. JONES of Ohio, Mr. GREEN of Texas, Mr. BERMAN, Mr. SERRANO, and Mr. McNULTY) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committees on Ways and Means, Rules, and Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend the Social Security Act to make corrections and refinements in the Medicare, Medicaid, and SCHIP health insurance programs, as revised by the Balanced Budget Act of 1997 and the Medicare, Medicaid, and

SCHIP Balanced Budget Refinement Act of 1999, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
 2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECU-**
 4 **RITY ACT; REFERENCES TO OTHER ACTS;**
 5 **TABLE OF CONTENTS.**

6 (a) SHORT TITLE.—This Act may be cited as the
 7 “Medicare, Medicaid, and SCHIP Balanced Budget Re-
 8 finement Act of 2000”.

9 (b) AMENDMENTS TO SOCIAL SECURITY ACT.—Ex-
 10 cept as otherwise specifically provided, whenever in this
 11 Act an amendment is expressed in terms of an amendment
 12 to or repeal of a section or other provision, the reference
 13 shall be considered to be made to that section or other
 14 provision of the Social Security Act.

15 (c) REFERENCES TO OTHER ACTS.—In this Act:

16 (1) THE BALANCED BUDGET ACT OF 1997.—
 17 The term “BBA” means the Balanced Budget Act
 18 of 1997 (Public Law 105–33; 111 Stat. 251).

19 (2) THE MEDICARE, MEDICAID, AND SCHIP
 20 BALANCED BUDGET REFINEMENT ACT OF 1999.—
 21 The term “BBRA” means the Medicare, Medicaid,
 22 and SCHIP Balanced Budget Refinement Act of
 23 1999 (113 Stat. 1501A–321), as enacted into law by
 24 section 1000(a)(6) of Public Law 106–113.

1 (d) TABLE OF CONTENTS.—The table of contents of
2 this Act is as follows:

Sec. 1. Short title; amendments to Social Security Act; references to other Acts;
table of contents.

TITLE I—PROVISIONS RELATING TO PART A

Subtitle A—Skilled Nursing Facilities

- Sec. 101. Eliminating reduction in skilled nursing facility (SNF) market basket update.
Sec. 102. Revision of BBRA increase for skilled nursing facilities in fiscal years 2001 and 2002.
Sec. 103. MedPAC study on payment updates for skilled nursing facilities; authority of Secretary to make adjustments.

Subtitle B—PPS Hospitals

- Sec. 111. Revision of reduction of indirect graduate medical education payments.
Sec. 112. Eliminating reduction in PPS hospital payment update.
Sec. 113. Eliminating reduction in disproportionate share hospital (DSH) payments.
Sec. 114. Equalizing the threshold and updating payment formulas for disproportionate share hospitals.
Sec. 115. Care for low-income patients.
Sec. 116. Modification of payment rate for Puerto Rico hospitals.
Sec. 117. MedPAC study on hospital area wage indexes.

Subtitle C—PPS Exempt Hospitals

- Sec. 121. Treatment of certain cancer hospitals.
Sec. 122. Payment adjustment for inpatient services in rehabilitation hospitals.

Subtitle D—Hospice Care

- Sec. 131. Revision in payments for hospice care.

Subtitle E—Other Provisions

- Sec. 141. Hospitals required to comply with bloodborne pathogens standard.
Sec. 142. Informatics and data systems grant program.
Sec. 143. Relief from medicare part A late enrollment penalty for group buy-in for State and local retirees.

Subtitle F—Transitional Provisions

- Sec. 151. Reclassification of certain counties and areas for purposes of reimbursement under the medicare program.
Sec. 152. Calculation and application of wage index floor for a certain area.
Sec. 153. Reclassification of a certain county for purposes of reimbursement under the medicare program.

TITLE II—PROVISIONS RELATING TO PART B

Subtitle A—Hospital Outpatient Services

- Sec. 201. Reduction of effective HOPD coinsurance rate to 20 percent by 2014.
- Sec. 202. Application of transitional corridor to certain hospitals that did not submit a 1996 cost report.
- Sec. 203. Permanent guarantee of pre-BBA payment levels for outpatient services furnished by children's hospitals.

Subtitle B—Provisions Relating to Physicians

- Sec. 211. Loan deferment for residents.
- Sec. 212. GAO studies and reports on medicare payments.
- Sec. 213. MedPAC study on the resource-based practice expense system.

Subtitle C—Ambulance Services

- Sec. 221. Election to forego phase-in of fee schedule for ambulance services.
- Sec. 222. Prudent layperson standard for emergency ambulance services.
- Sec. 223. Elimination of reduction in inflation adjustments for ambulance services.
- Sec. 224. Study and report on the costs of rural ambulance services.
- Sec. 225. Interim payments for rural ground ambulance services until regulation implemented.
- Sec. 226. GAO study and report on the costs of emergency and medical transportation services.

Subtitle D—Preventive Services

- Sec. 231. Elimination of deductibles and coinsurance for preventive benefits.
- Sec. 232. Counseling for cessation of tobacco use.
- Sec. 233. Coverage of glaucoma detection tests.
- Sec. 234. Medical nutrition therapy services for beneficiaries with diabetes, a cardiovascular disease, or a renal disease.
- Sec. 235. Studies on preventive interventions in primary care for older Americans.
- Sec. 236. Institute of Medicine 5-year medicare prevention benefit study and report.
- Sec. 237. Fast-track consideration of prevention benefit legislation.

Subtitle E—Other Services

- Sec. 241. Revision of moratorium in caps for therapy services.
- Sec. 242. Revision of coverage of immunosuppressive drugs.
- Sec. 243. State accreditation of diabetes self-management training programs.
- Sec. 244. Elimination of reduction in payment amounts for durable medical equipment and oxygen and oxygen equipment.
- Sec. 245. Standards regarding payment for certain orthotics and prosthetics.
- Sec. 246. National limitation amount equal to 100 percent of national median for new pap smear technologies and other new clinical laboratory test technologies.
- Sec. 247. Increased medicare payments for certified nurse-midwife services.
- Sec. 248. Payment for administration of drugs.
- Sec. 249. MedPAC study on in-home infusion therapy nursing services.
- Sec. 250. Coverage of vision rehabilitation services.
- Sec. 251. Limiting medicare late enrollment penalty to 10 percent and twice the period of no enrollment.

TITLE III—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

- Sec. 301. Elimination of 15 percent reduction in payment rates under the prospective payment system for home health services.
- Sec. 302. Additional payments for outliers.
- Sec. 303. Additional payments under the prospective payment system for services furnished in rural areas and security services.
- Sec. 304. Exclusion of certain nonroutine medical supplies under the PPS for home health services.
- Sec. 305. Clarification of the homebound definition for the home health benefit.
- Sec. 306. Standards for home health branch offices.
- Sec. 307. Treatment of home health services provided in certain counties.
- Sec. 308. Rule of construction relating to telehomehealth services.

Subtitle B—Direct Graduate Medical Education

- Sec. 311. Not counting certain geriatric residents against graduate medical education limitations.
- Sec. 312. Program of payments to children's hospitals that operate graduate medical education programs.
- Sec. 313. Authority to include costs of training of clinical psychologists in payments to hospitals.
- Sec. 314. Treatment of certain newly established residency programs in computing medicare payments for the costs of medical education.
- Sec. 315. Exception to establishing the number of residents for certain hospitals.

Subtitle C—Miscellaneous Provisions

- Sec. 321. Waiver of 24-month waiting period for medicare coverage of individuals disabled with amyotrophic lateral sclerosis (ALS).

TITLE IV—RURAL PROVIDER PROVISIONS

Subtitle A—Critical Access Hospitals

- Sec. 401. Payments to critical access hospitals for clinical diagnostic laboratory tests.
- Sec. 402. Revision of payment for professional services provided by a critical access hospital.
- Sec. 403. Permitting critical access hospitals to operate PPS exempt distinct part psychiatric and rehabilitation units.

Subtitle B—Medicare Dependent, Small Rural Hospital Program

- Sec. 411. Making the medicare dependent, small rural hospital program permanent.
- Sec. 412. Option to base eligibility for medicare dependent, small rural hospital program on discharges during any of the 3 most recent audited cost reporting periods.

Subtitle C—Sole Community Hospitals

- Sec. 421. Extension of option to use rebased target amounts to all sole community hospitals.
- Sec. 422. Deeming a certain hospital as a sole community hospital.

Subtitle D—Other Rural Hospital Provisions

- Sec. 431. Exemption of hospital swing-bed program from the PPS for skilled nursing facilities.
- Sec. 432. Permanent guarantee of pre-BBA payment levels for outpatient services furnished by rural hospitals.
- Sec. 433. Treatment of certain physician pathology services.

Subtitle E—Other Rural Provisions

- Sec. 441. Revision of bonus payments for services furnished in health professional shortage areas.
- Sec. 442. Provider-based rural health clinic cap exemption.
- Sec. 443. Payment for certain physician assistant services.
- Sec. 444. Exclusion of clinical social worker services and services performed under a contract with a rural health clinic or federally qualified health center from the PPS for SNFs.
- Sec. 445. Coverage of marriage and family therapist services provided in rural health clinics.
- Sec. 446. Capital infrastructure revolving loan program.
- Sec. 447. Grants for upgrading data systems.
- Sec. 448. Relief for financially distressed rural hospitals.
- Sec. 449. Refinement of medicare reimbursement for telehealth services.
- Sec. 450. MedPAC study on low-volume, isolated rural health care providers.

TITLE V—PROVISIONS RELATING TO PART C (MEDICARE+CHOICE PROGRAM) AND OTHER MEDICARE MAN- AGED CARE PROVISIONS

- Sec. 501. Restoring effective date of elections and changes of elections of Medicare+Choice plans.
- Sec. 502. Special Medigap enrollment antidiscrimination provision for certain beneficiaries.
- Sec. 503. Increase in national per capita Medicare+Choice growth percentage in 2001 and 2002.
- Sec. 504. Allowing movement to 50:50 percent blend in 2002.
- Sec. 505. Delay from July to November 2000, in deadline for offering and withdrawing Medicare+Choice plans for 2001.
- Sec. 506. Amounts in medicare trust funds available for Secretary's share of Medicare+Choice education and enrollment-related costs.
- Sec. 507. Revised terms and conditions for extension of medicare community nursing organization (CNO) demonstration project.
- Sec. 508. Modification of payment rules for certain frail elderly medicare beneficiaries.

TITLE VI—PROVISIONS RELATING TO INDIVIDUALS WITH END- STAGE RENAL DISEASE

- Sec. 601. Update in renal dialysis composite rate.
- Sec. 602. Revision of payment rates for ESRD patients enrolled in Medicare+Choice plans.
- Sec. 603. Permitting ESRD beneficiaries to enroll in another Medicare+Choice plan if the plan in which they are enrolled is terminated.
- Sec. 604. Coverage of certain vascular access services for ESRD beneficiaries provided by ambulatory surgical centers.
- Sec. 605. Collection and analysis of information on the satisfaction of ESRD beneficiaries with the quality of and access to health care under the medicare program.

TITLE VII—ACCESS TO CARE IMPROVEMENTS THROUGH
MEDICAID AND SCHIP

- Sec. 701. New prospective payment system for Federally-qualified health centers and rural health clinics.
- Sec. 702. Transitional medical assistance.
- Sec. 703. Application of simplified SCHIP procedures under the medicaid program.
- Sec. 704. Presumptive eligibility.
- Sec. 705. Improvements to the maternal and child health services block grant.
- Sec. 706. Improving access to medicare cost-sharing assistance for low-income beneficiaries.
- Sec. 707. Breast and cervical cancer prevention and treatment.

TITLE VIII—OTHER PROVISIONS

- Sec. 801. Appropriations for Ricky Ray Hemophilia Relief Fund.
- Sec. 802. Increase in appropriations for special diabetes programs for children with type I diabetes and Indians.
- Sec. 803. Demonstration grants to improve outreach, enrollment, and coordination of programs and services to homeless individuals and families.
- Sec. 804. Protection of an HMO enrollee to receive continuing care at a facility selected by the enrollee.
- Sec. 805. Grants to develop and establish real choice systems change initiatives.

1 **TITLE I—PROVISIONS RELATING**
2 **TO PART A**
3 **Subtitle A—Skilled Nursing**
4 **Facilities**

5 **SEC. 101. ELIMINATING REDUCTION IN SKILLED NURSING**
6 **FACILITY (SNF) MARKET BASKET UPDATE.**

7 (a) ELIMINATION OF REDUCTION.—Section
8 1888(e)(4)(E)(ii) (42 U.S.C. 1395yy(e)(4)(E)(ii)) is
9 amended—

- 10 (1) in subclause (I), by adding “and” at the
11 end;
- 12 (2) by striking subclause (II); and
- 13 (3) by redesignating subclause (III) as sub-
14 clause (II).

(b) SPECIAL RULE FOR PAYMENT FOR SKILLED NURSING FACILITY SERVICES FOR FISCAL YEAR 2001.— Notwithstanding the amendments made by subsection (a), for purposes of making payments for covered skilled nursing facility services under section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)) for fiscal year 2001, the Federal per diem rate referred to in paragraph (4)(E)(ii) of such section—

(1) for the period beginning on October 1, 2000, and ending on March 31, 2001, shall be the rate determined in accordance with subclause (II) of such paragraph as in effect on the day before the date of enactment of this Act; and

(2) for the period beginning on April 1, 2001, and ending on September 30, 2001, shall be the rate computed for fiscal year 2000 pursuant to subclause (I) of such paragraph increased by the skilled nursing facility market basket percentage change for fiscal year 2001 plus 1 percentage point.

SEC. 102. REVISION OF BBRA INCREASE FOR SKILLED NURSING FACILITIES IN FISCAL YEARS 2001 AND 2002.

(a) REVISION.—Section 101(d) of BBRA (113 Stat. 1501A–325) is amended—

(1) in paragraph (1)—

1 (A) by striking “4.0 percent for each such
 2 fiscal year” and inserting “the applicable per-
 3 cent (as defined in paragraph (3)) for each
 4 such fiscal year (or portion of such year)”; and
 5 (2) by adding at the end the following new
 6 paragraph:

7 “(3) APPLICABLE PERCENT DEFINED.—For
 8 purposes of this subsection, the term ‘applicable per-
 9 cent’ means, with respect to services provided
 10 during—

11 “(A) the period beginning on October 1,
 12 2000, and ending on March 31, 2001, 4.0 per-
 13 cent;

14 “(B) the period beginning on April 1,
 15 2001, and ending on September 30, 2001, 8.0
 16 percent; and

17 “(C) fiscal year 2002, 6.0 percent.

18 (b) EFFECTIVE DATE.—The amendments made by
 19 subsection (a) shall take effect as if included in the enact-
 20 ment of section 101 of BBRA (113 Stat. 1501A–324).

21 **SEC. 103. MEDPAC STUDY ON PAYMENT UPDATES FOR**
 22 **SKILLED NURSING FACILITIES; AUTHORITY**
 23 **OF SECRETARY TO MAKE ADJUSTMENTS.**

24 (a) STUDY.—The Medicare Payment Advisory Com-
 25 mission established under section 1805 of the Social Secu-

1 rity Act (42 U.S.C. 1395b–6) (in this section referred to
2 as “MedPAC”) shall conduct a study of nursing home
3 costs to determine the adequacy of payment rates (includ-
4 ing updates to such rates) under the medicare program
5 under title XVIII of such Act (42 U.S.C. 1395 et seq.)
6 (in this section referred to as the “medicare program”)
7 for items and services furnished by skilled nursing facili-
8 ties. In conducting such study, MedPAC shall use data
9 on actual costs and cost increases.

10 (b) REPORT.—Not later than 12 months after the
11 date of enactment of this Act, MedPAC shall submit a
12 report to the Secretary of Health and Human Services and
13 Congress on the study conducted under subsection (a), in-
14 cluding a description of the methodology and calculations
15 used by the Health Care Financing Administration to es-
16 tablish the original payment level under the prospective
17 payment system for skilled nursing facility services under
18 section 1888(e) of the Social Security Act (42 U.S.C.
19 1395yy(e)) and to annually update payments under the
20 medicare program for items and services furnished by
21 skilled nursing facilities, together with recommendations
22 regarding methods to ensure that all input variables, in-
23 cluding the labor costs, the intensity of services, and the
24 changes in science and technology that are specific to such
25 facilities, are adequately accounted for.

1 (c) AUTHORITY OF SECRETARY TO MAKE ADJUST-
 2 MENTS.—Notwithstanding any other provision of law, the
 3 Secretary of Health and Human Services may make ad-
 4 justments to payments under the prospective payment sys-
 5 tem under section 1888(e) of the Social Security Act (42
 6 U.S.C. 1395yy(e)) for covered skilled nursing facility serv-
 7 ices to reflect any necessary adjustments to such payments
 8 as is appropriate as a result of the study conducted under
 9 subsection (a).

10 (d) PUBLICATION.—

11 (1) IN GENERAL.—Not later than April 1,
 12 2002, the Secretary of Health and Human Services
 13 shall publish for public comment a description of—

14 (A) whether the Secretary will make any
 15 adjustments pursuant to subsection (c); and

16 (B) if so, the form of such adjustments.

17 (2) FINAL FORM.—Not later than August 1,
 18 2002, the Secretary of Health and Human Services
 19 shall publish the description described in paragraph
 20 (1) in final form.

21 **Subtitle B—PPS Hospitals**

22 **SEC. 111. REVISION OF REDUCTION OF INDIRECT GRAD-** 23 **UATE MEDICAL EDUCATION PAYMENTS.**

24 (a) REVISION.—

1 (1) IN GENERAL.—Section 1886(d)(5)(B)(ii)
 2 (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

3 (A) in subclause (IV), by adding “and” at
 4 the end; and

5 (B) by striking subclauses (V) and (VI)
 6 and inserting the following new subclause:

7 “(V) on or after October 1, 2000, ‘c’
 8 is equal to 1.6.”.

9 (2) TECHNICAL AMENDMENTS.—Section
 10 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)), as
 11 amended by paragraph (1), is amended—

12 (A) by realigning the left margins of
 13 clauses (ii) and (v) so as to align with the left
 14 margin of clause (i); and

15 (B) by realigning the left margins of sub-
 16 clauses (I) through (V) of clause (ii) appro-
 17 priately.

18 (b) SPECIAL ADJUSTMENT FOR PURPOSES OF MAIN-
 19 TAINING 6.5 PERCENT IME PAYMENT FOR FISCAL YEAR
 20 2001.—Notwithstanding paragraph (5)(B)(ii)(V) of sec-
 21 tion 1886(d) of the Social Security Act (42 U.S.C.
 22 1395ww(d)(5)(B)(ii)(V)), as amended by subsection (a),
 23 for purposes of making payments for subsection (d) hos-
 24 pitals (as defined in paragraph (1)(B) of such section)
 25 with indirect costs of medical education, the indirect

1 teaching adjustment factor referred to in paragraph
2 (5)(B)(ii) of such section shall be determined—

3 (1) for discharges occurring on or after October
4 1, 2000, and before April 1, 2001, pursuant to such
5 paragraph as in effect on the day before the date of
6 enactment of this Act; and

7 (2) for discharges occurring on or after April 1,
8 2001, and before October 1, 2001, by substituting
9 “1.66” for “1.6” in subclause (V) of such paragraph
10 (as so amended).

11 (c) CONFORMING AMENDMENT RELATING TO DE-
12 TERMINATION OF STANDARDIZED AMOUNT.—Section
13 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is
14 amended—

15 (1) by inserting a comma after “Balanced
16 Budget Act of 1997”; and

17 (2) by inserting “, or any payment under such
18 paragraph resulting from the application of section
19 111(b) of the Medicare, Medicaid, and SCHIP Bal-
20 anced Budget Refinement Act of 2000” after “Bal-
21 anced Budget Refinement Act of 1999”.

22 **SEC. 112. ELIMINATING REDUCTION IN PPS HOSPITAL PAY-**
23 **MENT UPDATE.**

24 (a) IN GENERAL.—Section 1886(b)(3)(B)(i) (42
25 U.S.C. 1395ww(b)(3)(B)(i)) is amended—

1 (1) in subclause (XV), by adding “and” at the
 2 end;

3 (2) by striking subclauses (XVI) and (XVII);

4 (3) by redesignating subclause (XVIII) as sub-
 5 clause (XVI); and

6 (4) in subclause (XVI), as so redesignated, by
 7 striking “fiscal year 2003” and inserting “fiscal year
 8 2001”.

9 (b) SPECIAL RULE FOR PAYMENT FOR INPATIENT
 10 HOSPITAL SERVICES FOR FISCAL YEAR 2001.—Notwith-
 11 standing the amendments made by subsection (a), for pur-
 12 poses of making payments for fiscal year 2001 for inpa-
 13 tient hospital services furnished by subsection (d) hos-
 14 pitals (as defined in section 1886(d)(1)(B) of the Social
 15 Security Act (42 U.S.C. 1395ww(d)(1)(B))), the “applica-
 16 ble percentage increase” referred to in section
 17 1886(b)(3)(B)(i) of such Act (42 U.S.C.
 18 1395ww(b)(3)(B)(i))—

19 (1) for discharges occurring on or after October
 20 1, 2000, and before April 1, 2001, shall be deter-
 21 mined in accordance with subclause (XVI) of such
 22 section as in effect on the day before the date of en-
 23 actment of this Act; and

(2) for discharges occurring on or after April 1, 2001, and before October 1, 2001, shall be equal to—

(A) the market basket percentage increase plus 1.1 percentage points for hospitals (other than sole community hospitals) in all areas; and

(B) the market basket percentage increase for sole community hospitals.

SEC. 113. ELIMINATING REDUCTION IN DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS.

(a) ELIMINATION OF REDUCTION.—

(1) IN GENERAL.—Section 1886(d)(5)(F)(ix) (42 U.S.C. 1395ww(d)(5)(F)(ix)) is amended—

(A) in subclause (III), by striking “during each of fiscal years 2000 and 2001” and inserting “during fiscal year 2000”;

(B) by striking subclause (IV);

(C) by redesignating subclause (V) as subclause (IV); and

(D) in subclause (IV), as so redesignated, by striking “during fiscal year 2003” and inserting “during fiscal year 2001”.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to discharges occurring on or after October 1, 2000.

1 (b) SPECIAL RULE FOR DSH PAYMENT FOR FISCAL
 2 YEAR 2001.—Notwithstanding the amendments made by
 3 subsection (a)(1), for purposes of making disproportionate
 4 share payments for subsection (d) hospitals (as defined
 5 in section 1886(d)(1)(B) of the Social Security Act (42
 6 U.S.C. 1395ww(d)(1)(B))) for fiscal year 2001, the addi-
 7 tional payment amount otherwise determined under clause
 8 (ii) of section 1886(d)(5)(F) of the Social Security Act
 9 (42 U.S.C. 1395ww(d)(5)(F))—

10 (1) for discharges occurring on or after October
 11 1, 2000, and before April 1, 2001, shall be adjusted
 12 as provided by clause (ix)(III) of such section as in
 13 effect on the day before the date of enactment of
 14 this Act; and

15 (2) for discharges occurring on or after April 1,
 16 2001, and before October 1, 2001, shall be increased
 17 by 3 percent.

18 (c) CONFORMING AMENDMENTS RELATING TO DE-
 19 TERMINATION OF STANDARDIZED AMOUNT.—Section
 20 1886(d)(2)(C)(iv) (42 U.S.C. 1395ww(d)(2)(C)(iv)), is
 21 amended—

22 (1) by striking “Act of 1989 or” and inserting
 23 “Act of 1989,”; and

24 (2) by inserting “, or the enactment of section
 25 113(b) of the Medicare, Medicaid, and SCHIP Bal-

1 anced Budget Refinement Act of 2000” after “Om-
2 nibus Budget Reconciliation Act of 1990”.

3 **SEC. 114. EQUALIZING THE THRESHOLD AND UPDATING**
4 **PAYMENT FORMULAS FOR DISPROPOR-**
5 **TIONATE SHARE HOSPITALS.**

6 (a) APPLICATION OF UNIFORM 15 PERCENT
7 THRESHOLD.—Section 1886(d)(5)(F)(v) (42 U.S.C.
8 1395ww(d)(5)(F)(v)) is amended by striking “exceeds—
9 ” and all that follows and inserting “exceeds 15 percent.”.

10 (b) CHANGE IN PAYMENT PERCENTAGE FOR-
11 MULAS.—Section 1886(d)(5)(F)(viii) (42 U.S.C.
12 1395ww(d)(5)(F)(viii)) is amended to read as follows:

13 “(viii) The formula used to determine the dispropor-
14 tionate share adjustment percentage for a cost reporting
15 period for a hospital described in subclause (II), (III), or
16 (IV) of clause (iv) is—

17 “(I) in the case of such a hospital with a dis-
18 proportionate patient percentage (as defined in
19 clause (vi)) that does not exceed 20.2, $(P-15)(.65)$
20 $+ 2.5$;

21 “(II) in the case of such a hospital with a dis-
22 proportionate patient percentage (as so defined) that
23 exceeds 20.2 but does not exceed 25.2, $(P-$
24 $20.2)(.825) + 5.88$;

1 “(III) except as provided in subclause (IV), in
 2 the case of such a hospital with a disproportionate
 3 patient percentage (as so defined) that exceeds 25.2,
 4 the disproportionate share adjustment percentage =
 5 10; and

6 “(IV) in the case of such a hospital with a dis-
 7 proportionate patient percentage (as so defined) that
 8 exceeds 30.0 and that is described in clause (iv)(III),
 9 $(P-30)(.6) + 10$;

10 where ‘P’ is the hospital’s disproportionate patient per-
 11 centage (as so defined).”.

12 (c) CONFORMING AMENDMENTS.—Section
 13 1886(d)(5)(F)(iv) (42 U.S.C. 1395ww(d)(5)(F)(iv)) is
 14 amended—

15 (1) in subclause (I), by striking “is described in
 16 the second sentence of clause (v)” and inserting “is
 17 located in a rural area and has 500 or more beds”;

18 (2) by amending subclause (II) to read as fol-
 19 lows:

20 “(II) is located in an urban area and has less
 21 than 100 beds, or is located in a rural area and has
 22 less than 500 beds and is not described in subclause
 23 (III) or (IV), is equal to the percent determined in
 24 accordance with the applicable formula described in
 25 clause (viii);”;

1 (3) by striking subclauses (III) and (IV);

2 (4) by redesignating subclauses (V) and (VI) as
3 subclauses (III) and (IV), respectively;

4 (5) in subclause (III) (as so redesignated), by
5 striking “and is not classified as a sole community
6 hospital under subparagraph (D),”; and

7 (6) in subclause (IV) (as so redesignated), by
8 striking “10 percent” and inserting “equal to the
9 percent determined in accordance with the applicable
10 formula described in clause (viii)”.

11 (d) EFFECTIVE DATE.—The amendments made by
12 this section shall apply to discharges occurring on or after
13 April 1, 2001.

14 **SEC. 115. CARE FOR LOW-INCOME PATIENTS.**

15 (a) FREEZE IN MEDICAID DSH ALLOTMENTS.—

16 (1) IN GENERAL.—Section 1923(f) (42 U.S.C.
17 1396r–4(f)) is amended—

18 (A) by redesignating paragraph (4) as
19 paragraph (5); and

20 (B) by inserting after paragraph (3), the
21 following new paragraph:

22 “(4) SPECIAL RULE FOR FISCAL YEARS 2001
23 THROUGH 2008.—With respect to each of fiscal years
24 2001 through 2008—

25 “(A) paragraph (2) shall be applied—

1 “(i) by substituting—

2 “(I) in the heading, ‘2001’ for
3 ‘2002’;

4 “(II) in the matter preceding the
5 table, ‘2001 (and the DSH allotment
6 for a State for fiscal year 2001 is the
7 same as the DSH allotment for the
8 State for fiscal year 2000, as deter-
9 mined under the following table)’ for
10 ‘2002’; and

11 “(ii) without regard to the columns in
12 the table relating to FY 01 and FY 02
13 (fiscal years 2001 and 2002); and

14 “(B) paragraph (3) shall be applied by
15 substituting—

16 “(i) in the heading, ‘2002’ for ‘2003’;

17 “(ii) in subparagraph (A), ‘2002’ for
18 ‘2003’.”.

19 (2) REPEAL; APPLICABILITY.—Effective Octo-
20 ber 1, 2008, the amendments made by paragraph
21 (1) are repealed and section 1923(f) of the Social
22 Security Act (42 U.S.C. 1396r–4(f)) shall be applied
23 and administered as if such amendments had not
24 been enacted.

1 (b) INCREASE IN DSH ALLOTMENTS FOR THE DIS-
2 TRICT OF COLUMBIA.—

3 (1) IN GENERAL.—Each of the entries in the
4 table in section 1923(f)(2) (42 U.S.C. 1396r-
5 4(f)(2)) relating to the District of Columbia for FY
6 98 (fiscal year 1998), for FY 99 (fiscal year 1999),
7 for FY 00 (fiscal year 2000), for FY 01 (fiscal year
8 2001), and for FY 02 (fiscal year 2002) are amend-
9 ed by striking the amount otherwise specified and
10 inserting “43.4”.

11 (2) EFFECTIVE DATE.—The amendments made
12 by paragraph (1) shall take effect as if included in
13 the enactment of section 4721(a) of BBA (111 Stat.
14 511).

15 (c) OPTIONAL ELIGIBILITY OF CERTAIN ALIEN
16 PREGNANT WOMEN AND CHILDREN FOR MEDICAID AND
17 SCHIP.—

18 (1) MEDICAID.—Section 1903(v) (42 U.S.C.
19 1396b(v)) is amended—

20 (A) in paragraph (1), by striking “para-
21 graph (2)” and inserting “paragraphs (2) and
22 (4)”; and

23 (B) by adding at the end the following new
24 paragraph:

1 “(4)(A) A State may elect (in a plan amendment
2 under this title) to provide medical assistance under this
3 title, notwithstanding sections 401(a), 402(b), 403, and
4 421 of the Personal Responsibility and Work Opportunity
5 Reconciliation Act of 1996, for aliens who are lawfully re-
6 siding in the United States (including battered aliens de-
7 scribed in section 431(c) of such Act) and who are other-
8 wise eligible for such assistance, within any of the fol-
9 lowing eligibility categories:

10 “(i) PREGNANT WOMEN.—Women during preg-
11 nancy (and during the 60-day period beginning on
12 the last day of the pregnancy).

13 “(ii) CHILDREN.—Children (as defined under
14 such plan), including optional targeted low-income
15 children described in section 1905(u)(2)(B).

16 “(B) In the case of a State that has elected to provide
17 medical assistance to a category of aliens under subpara-
18 graph (A), no action may be brought under an affidavit
19 of support against any sponsor of such an alien on the
20 basis of provision of assistance to such category.”.

21 “(2) SCHIP.—Section 2107(e)(1) (42 U.S.C.
22 1397gg(e)(1)) is amended by adding at the end the
23 following new subparagraph:

24 “(D) Section 1903(v)(4)(A)(ii) (relating to
25 optional coverage of permanent resident alien

1 children), but only if the State has in effect an
 2 election under that same eligibility category for
 3 purposes of title XIX.”.

4 (3) EFFECTIVE DATE.—The amendments made
 5 by this section take effect on October 1, 2000, and
 6 apply to medical assistance and child health assist-
 7 ance furnished on or after such date.

8 **SEC. 116. MODIFICATION OF PAYMENT RATE FOR PUERTO**
 9 **RICO HOSPITALS.**

10 (a) MODIFICATION OF PAYMENT RATE.—Section
 11 1886(d)(9)(A) (42 U.S.C. 1395ww(d)(9)(A)) is
 12 amended—

13 (1) in clause (i), by striking “October 1, 1997,
 14 50 percent (” and inserting “October 1, 2000, 25
 15 percent (for discharges between October 1, 1997,
 16 and September 30, 2000, 50 percent,”; and

17 (2) in clause (ii), in the matter preceding sub-
 18 clause (I), by striking “after October 1, 1997, 50
 19 percent (” and inserting “after October 1, 2000, 75
 20 percent (for discharges between October 1, 1997,
 21 and September 30, 2000, 50 percent,”.

22 (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR
 23 2001.—

24 (1) IN GENERAL.—Notwithstanding the amend-
 25 ment made by subsection (a), for purposes of mak-

1 ing payments for the operating costs of inpatient
2 hospital services of a section 1886(d) Puerto Rico
3 hospital for fiscal year 2001, the amount referred to
4 in the matter preceding clause (i) of section
5 1886(d)(9)(A) of the Social Security Act (42 U.S.C.
6 1395ww(d)(9)(A))—

7 (A) for discharges occurring on or after
8 October 1, 2000, and before April 1, 2001,
9 shall be determined in accordance with such
10 section as in effect on the day before the date
11 of enactment of this Act; and

12 (B) for discharges occurring on or after
13 April 1, 2001, and before October 1, 2001,
14 shall be determined—

15 (i) using 0 percent of the Puerto Rico
16 adjusted DRG prospective payment rate
17 referred to in clause (i) of such section;
18 and

19 (ii) using 100 percent of the dis-
20 charge-weighted average referred to in
21 clause (ii) of such section.

22 (2) SECTION 1886(d) PUERTO RICO HOSPITAL.—

23 For purposes of this subsection, the term “section
24 1886(d) Puerto Rico hospital” has the meaning
25 given the term “subsection (d) Puerto Rico hospital”

1 in the last sentence of section 1886(d)(9)(A) of the
2 Social Security Act (42 U.S.C. 1395ww(d)(9)(A)).

3 **SEC. 117. MEDPAC STUDY ON HOSPITAL AREA WAGE IN-**
4 **DEXES.**

5 (a) STUDY.—

6 (1) IN GENERAL.—The Medicare Payment Ad-
7 visory Commission established under section 1805 of
8 the Social Security Act (42 U.S.C. 1395b–6) (in this
9 section referred to as “MedPAC”) shall conduct a
10 study on the hospital area wage indexes used in
11 making payments to hospitals under section 1886(d)
12 of the Social Security Act (42 U.S.C. 1395ww(d)),
13 including an assessment of the accuracy of those in-
14 dexes in reflecting geographic differences in wage
15 and wage-related costs of hospitals.

16 (2) CONSIDERATIONS.—In conducting the study
17 under paragraph (1), MedPAC shall consider—

18 (A) the appropriate method for deter-
19 mining hospital area wage indexes;

20 (B) the appropriate portion of hospital
21 payments that should be adjusted by the appli-
22 cable area wage index;

23 (C) the appropriate method for adjusting
24 the wage index by occupational mix; and

1 (D) the feasibility and impact of making
 2 changes (as determined appropriate by
 3 MedPAC) to the methods used to determine
 4 such indexes, including the need for a data sys-
 5 tem required to implement such changes.

6 (b) REPORT.—Not later than 18 months after the
 7 date of enactment of this Act, MedPAC shall submit a
 8 report to the Secretary of Health and Human Services and
 9 Congress on the study conducted under subsection (a) to-
 10 gether with such recommendations for legislation and ad-
 11 ministrative action as MedPAC determines appropriate.

12 **Subtitle C—PPS Exempt Hospitals**

13 **SEC. 121. TREATMENT OF CERTAIN CANCER HOSPITALS.**

14 (a) IN GENERAL.—Section 1886(d)(1)(B)(v) of the
 15 Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(v)) is
 16 amended—

17 (1) in subclause (I), by striking “or” at the
 18 end;

19 (2) in subclause (II), by striking the semicolon
 20 at the end and inserting “, or”; and

21 (3) by adding at the end the following:

22 “(III) a hospital that was recognized as a clin-
 23 ical cancer research center by the National Cancer
 24 Institute of the National Institutes of Health as of
 25 February 18, 1998, that has never been reimbursed

1 for inpatient hospital services pursuant to a reim-
 2 bursement system under a demonstration project
 3 under section 1814(b), that is a freestanding facility
 4 organized primarily for treatment of and research on
 5 cancer and is not a unit of another hospital, that as
 6 of the date of enactment of this subclause, is li-
 7 censed for 162 acute care beds, and that dem-
 8 onstrates for the 4-year period ending on June 30,
 9 1999, that at least 50 percent of its total discharges
 10 have a principal finding of neoplastic disease, as de-
 11 fined in subparagraph (E);”.

12 (b) CONFORMING AMENDMENT.—Section
 13 1886(d)(1)(E) of the Social Security Act (42 U.S.C.
 14 1395ww(d)(1)(E)) is amended by striking “For purposes
 15 of subparagraph (B)(v)(II)” and inserting “For purposes
 16 of subclauses (II) and (III) of subparagraph (B)(v)”.

17 (c) PAYMENT.—

18 (1) APPLICATION TO COST REPORTING PERI-
 19 ODS.—Any classification by reason of section
 20 1886(d)(1)(B)(v)(III) of the Social Security Act (as
 21 added by subsection (a)) shall apply to 12-month
 22 cost reporting periods beginning on or after July 1,
 23 1999.

24 (2) BASE YEAR.—Notwithstanding the provi-
 25 sions of section 1886(b)(3)(E) of such Act (42

1 U.S.C. 1395ww(b)(3)(E)) or other provisions to the
 2 contrary, the base cost reporting period for purposes
 3 of determining the target amount for any hospital
 4 classified by reason of section 1886(d)(1)(B)(v)(III)
 5 of such Act (as added by subsection (a)) shall be the
 6 12-month cost reporting period beginning on July 1,
 7 1995.

8 (3) DEADLINE FOR PAYMENTS.—Any payments
 9 owed to a hospital by reason of this subsection shall
 10 be made expeditiously, but in no event later than 1
 11 year after the date of enactment of this Act.

12 **SEC. 122. PAYMENT ADJUSTMENT FOR INPATIENT SERV-**
 13 **ICES IN REHABILITATION HOSPITALS.**

14 (a) OPTION TO APPLY PROSPECTIVE PAYMENT SYS-
 15 TEM DURING TRANSITION PERIOD.—Section
 16 1886(j)(1)(A) (42 U.S.C. 1395ww(j)(1)(A)) is amended in
 17 the matter preceding subclause (i) by inserting “the great-
 18 er of the prospective payment rate determined in para-
 19 graph (3)(A) or” after “is equal to”.

20 (b) INCREASE IN PROSPECTIVE PAYMENT PERCENT-
 21 AGE DURING TRANSITION PERIOD.—Section
 22 1886(j)(1)(A)(ii)(I) (42 U.S.C. 1395ww(j)(1)(A)(ii)(I)) is
 23 amended by inserting “102 percent of” before “the per
 24 unit”.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall take effect as if included in the enact-
3 ment of section 4421 of BBA (111 Stat. 410).

4 **Subtitle D—Hospice Care**

5 **SEC. 131. REVISION IN PAYMENTS FOR HOSPICE CARE.**

6 (a) INCREASE.—Section 1814(i)(1)(C) of the Social
7 Security Act (42 U.S.C. 1395f(i)(1)(C)) is amended—

8 (1) in clause (i), by adding at the end the fol-
9 lowing new sentence: “With respect to routine home
10 care and other services included in hospice care fur-
11 nished during fiscal year 2001, the payment rates
12 for such care and services for such fiscal year shall
13 be 110 percent of such rates as would otherwise be
14 in effect for such fiscal year (taking into account the
15 increase under clause (ii) but not taking into ac-
16 count the increase under section 131 of the Medi-
17 care, Medicaid, and SCHIP Balanced Budget Re-
18 finement Act of 1999), and such payment rates shall
19 be used in determining payments for such care and
20 services furnished in a subsequent fiscal year under
21 clause (ii).”; and

22 (2) in clause (ii), by striking “during a subse-
23 quent fiscal year” and inserting “during a fiscal
24 year beginning after September 30, 1990”.

1 (b) ELIMINATING REDUCTION IN UPDATE.—Section
 2 1814(i)(1)(C)(ii) of the Social Security Act (42 U.S.C.
 3 1395f(i)(1)(C)(ii)) is amended—

4 (1) in subclause (VI), by striking “through
 5 2002” and inserting “through 2000”; and

6 (2) in subclause (VII), by striking “for a subse-
 7 quent fiscal year” and inserting “for fiscal year
 8 2001 and each subsequent fiscal year”.

9 (c) SPECIAL RULE FOR PAYMENT FOR HOSPICE
 10 CARE FOR FISCAL YEAR 2001.—Notwithstanding the
 11 amendments made by subsections (a) and (b), for pur-
 12 poses of making payments under section 1814(i)(1)(C) of
 13 the Social Security Act (42 U.S.C. 1395f(i)(1)(C)) for
 14 routine home care and other services included in hospice
 15 care furnished during fiscal year 2001, such payment
 16 rates shall be determined—

17 (1) for the period beginning on October 1,
 18 2000, and ending on March 31, 2001, in accordance
 19 with such section as in effect on the day before the
 20 date of enactment of this Act; and

21 (2) for the period beginning on April 1, 2001,
 22 and ending on September 30, 2001—

23 (A) by substituting “120 percent” for
 24 “110 percent” in the second sentence of clause

1 (i) of such section (as added by subsection
 2 (a)(1)); and
 3 (B) as if the increase under subclause
 4 (ii)(VII) (as amended by subsection (b)) for fis-
 5 cal year 2001 was equal to the market basket
 6 increase for the fiscal year plus 1.0 percentage
 7 point.

8 **Subtitle E—Other Provisions**

9 **SEC. 141. HOSPITALS REQUIRED TO COMPLY WITH** 10 **BLOODBORNE PATHOGENS STANDARD.**

11 (a) AGREEMENTS WITH HOSPITALS.—Section
 12 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

13 (1) in subparagraph (R), by striking “and” at
 14 the end;

15 (2) in subparagraph (S), by striking the period
 16 at the end and inserting “, and”; and

17 (3) by inserting after subparagraph (S) the fol-
 18 lowing new subparagraph:

19 “(T) in the case of hospitals that are not other-
 20 wise subject to regulation by the Occupational Safe-
 21 ty and Health Administration, to comply with the
 22 Bloodborne Pathogens standard under section
 23 1910.1030 of title 29 of the Code of Federal Regula-
 24 tions.”.

1 (b) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to agreements in effect on or after
3 the date that is 1 year after the date of enactment of this
4 Act.

5 **SEC. 142. INFORMATICS AND DATA SYSTEMS GRANT PRO-**
6 **GRAM.**

7 (a) GRANTS TO HOSPITALS.—

8 (1) IN GENERAL.—The Secretary of Health and
9 Human Services (in this section referred to as the
10 “Secretary”) shall establish a program to make
11 grants to hospitals that have submitted applications
12 in accordance with subsection (c) to assist such hos-
13 pitals in offsetting the costs related to—

14 (A) developing and implementing standard-
15 ized clinical health care informatics systems de-
16 signed to improve medical care and reduce ad-
17 verse events and health care complications re-
18 sulting from medication errors; and

19 (B) establishing data systems to comply
20 with the administrative simplification require-
21 ments under part C of title XI of the Social Se-
22 curity Act (42 U.S.C. 1320d et seq.).

23 (2) COSTS.—For purposes of paragraph (1),
24 the term “costs” shall include costs associated
25 with—

1 (A) purchasing computer software and
2 hardware; and

3 (B) providing education and training to
4 hospital staff on computer information systems.

5 (3) DURATION.—The authority of the Secretary
6 to make grants under this section shall terminate on
7 September 30, 2011.

8 (4) LIMITATION.—A hospital that has received
9 a grant under section 1611 of the Public Health
10 Service Act (as added by section 447 of this Act) is
11 not eligible to receive a grant under this section.

12 (b) SPECIAL CONSIDERATION FOR LARGE URBAN
13 HOSPITALS.—In awarding grants under this section, the
14 Secretary shall give special consideration to hospitals lo-
15 cated in large urban areas (as defined for purposes of sec-
16 tion 1886(d) of the Social Security Act (42 U.S.C.
17 1395ww(d))).

18 (c) APPLICATION.—A hospital seeking a grant under
19 this section shall submit an application to the Secretary
20 at such time and in such form and manner as the Sec-
21 retary specifies.

22 (d) REPORTS.—

23 (1) INFORMATION.—A hospital receiving a
24 grant under this section shall furnish the Secretary

1 with such information as the Secretary may require
2 to—

3 (A) evaluate the project for which the
4 grant is made; and

5 (B) ensure that the grant is expended for
6 the purposes for which it is made.

7 (2) TIMING OF SUBMISSION.—

8 (A) INTERIM REPORTS.—The Secretary
9 shall report to the Committee on Ways and
10 Means of the House of Representatives and the
11 Committee on Finance of the Senate at least
12 annually on the grant program established
13 under this section, including in such report in-
14 formation on the number of grants made, the
15 nature of the projects involved, the geographic
16 distribution of grant recipients, and such other
17 matters as the Secretary deems appropriate.

18 (B) FINAL REPORT.—The Secretary shall
19 submit a final report to such committees not
20 later than 180 days after the completion of all
21 of the projects for which a grant is made under
22 this section.

23 (e) AUTHORIZATION OF APPROPRIATIONS.—There
24 are authorized to be appropriated from the Federal Hos-
25 pital Insurance Trust Fund under section 1817 of the So-

1 cial Security Act (42 U.S.C. 1395i) \$25,000,000 for each
 2 of the fiscal years 2001 through 2011 for the purposes
 3 of making grants under this section.

4 **SEC. 143. RELIEF FROM MEDICARE PART A LATE ENROLL-**
 5 **MENT PENALTY FOR GROUP BUY-IN FOR**
 6 **STATE AND LOCAL RETIREES.**

7 Section 1818(d) (42 U.S.C. 1395i–2(d)) is amended
 8 by adding at the end the following new paragraph:

9 “(6)(A) In the case where a State, a political
 10 subdivision of a State, or an agency or instrumen-
 11 tality of a State or political subdivision thereof de-
 12 termines to pay, for the life of each individual, the
 13 monthly premiums due under paragraph (1) on be-
 14 half of each of the individuals in a qualified State
 15 or local government retiree group who meets the
 16 conditions of subsection (a), the amount of any in-
 17 crease otherwise applicable under section 1839(b)
 18 (as modified by subsection (c)(6) of this section)
 19 with respect to the monthly premium for benefits
 20 under this part for an individual who is a member
 21 of such group shall be reduced by the total amount
 22 of taxes paid under section 3101(b) of the Internal
 23 Revenue Code of 1986 by such individual and under
 24 section 3111(b) by the employers of such individual

1 on behalf of such individual with respect to employ-
 2 ment (as defined in section 3121(b) of such Code).

3 “(B) For purposes of this paragraph, the term
 4 ‘qualified State or local government retiree group’
 5 means all of the individuals who retire prior to a
 6 specified date that is before January 1, 2002, from
 7 employment in 1 or more occupations or other broad
 8 classes of employees of—

9 “(i) the State;

10 “(ii) a political subdivision of the State; or

11 “(iii) an agency or instrumentality of the
 12 State or political subdivision of the State.”.

13 **Subtitle F—Transitional Provisions**

14 **SEC. 151. RECLASSIFICATION OF CERTAIN COUNTIES AND** 15 **AREAS FOR PURPOSES OF REIMBURSEMENT** 16 **UNDER THE MEDICARE PROGRAM.**

17 (a) FISCAL YEARS 2002 THROUGH 2004.—Notwith-
 18 standing any other provision of law, effective for dis-
 19 charges occurring during fiscal years 2002, 2003, and
 20 2004, for purposes of making payments under section
 21 1886(d) of the Social Security Act (42 U.S.C.
 22 1395ww(d))—

23 (1) Iredell County, North Carolina is deemed to
 24 be located in the Charlotte-Gastonia-Rock Hill,

1 North Carolina-South Carolina Metropolitan Statis-
2 tical Area; and

3 (2) the large urban area of New York, New
4 York is deemed to include Orange County, New
5 York (including hospitals that have been reclassified
6 into such county).

7 For purposes of that section, any reclassification under
8 this subsection shall be treated as a decision of the Medi-
9 care Geographic Classification Review Board under para-
10 graph (10) of that section.

11 (b) FISCAL YEARS 2001 THROUGH 2003.—Notwith-
12 standing any other provision of law, effective for dis-
13 charges occurring during fiscal years 2001, 2002, and
14 2003, for purposes of making payments under section
15 1886(d) of the Social Security Act (42 U.S.C.
16 1395ww(d))—

17 (1) the Jackson, Michigan Metropolitan Statis-
18 tical Area is deemed to be located in the Ann Arbor,
19 Michigan Metropolitan Statistical Area;

20 (2) Tangipahoa Parish, Louisiana is deemed to
21 be located in the New Orleans, Louisiana Metropoli-
22 tan Statistical Area; and

23 (3) the large urban area of New York, New
24 York is deemed to include Dutchess County, New
25 York.

1 For purposes of that section, any reclassification under
 2 this subsection shall be treated as a decision of the Medi-
 3 care Geographic Classification Review Board under para-
 4 graph (10) of that section.

5 (c) TECHNICAL CORRECTION TO BBRA.—

6 (1) IN GENERAL.—Section 152 of BBRA (113
 7 Stat. 1501A–334) is amended—

8 (A) in subsection (a)(2), by inserting “(in-
 9 cluding hospitals that have been reclassified
 10 into such county)” after “such county”; and

11 (B) in subsection (b)(2), by inserting “(in-
 12 cluding hospitals that have been reclassified
 13 into such county)” after “Orange County, New
 14 York”; and

15 (2) EFFECTIVE DATE.—The amendments made
 16 by paragraph (1) shall take effect as if included in
 17 the enactment of section 152 of BBRA (113 Stat.
 18 1501A–334).

19 **SEC. 152. CALCULATION AND APPLICATION OF WAGE**
 20 **INDEX FLOOR FOR A CERTAIN AREA.**

21 Notwithstanding any other provision of section
 22 1886(d) of the Social Security Act (42 U.S.C.
 23 1395ww(d)), for discharges occurring during fiscal year
 24 2000, the Secretary of Health and Human Services shall
 25 calculate and apply the wage index for the Barnstable-

1 Yarmouth Metropolitan Statistical Area under that sec-
2 tion as if the Jordan Hospital were classified in such area
3 for purposes of payment under that section for such fiscal
4 year. Such recalculation shall not affect the wage index
5 for any other area.

6 **SEC. 153. RECLASSIFICATION OF A CERTAIN COUNTY FOR**
7 **PURPOSES OF REIMBURSEMENT UNDER THE**
8 **MEDICARE PROGRAM.**

9 (a) IN GENERAL.—Notwithstanding any other provi-
10 sion of law, effective for discharges occurring on or after
11 October 1, 2000, for purposes of making payments under
12 section 1886(d) of the Social Security Act (42 U.S.C.
13 1395ww(d)) to a covered hospital in Boston, Metropolitan
14 Statistical Area, such covered hospital is deemed to be lo-
15 cated in the Barnstable-Yarmouth, Metropolitan Statis-
16 tical Area.

17 (b) COVERED HOSPITAL DEFINED.—In subsection
18 (a), the term “covered hospital” means a subsection (d)
19 hospital (as defined in paragraph (1)(B) of such section
20 1886(d)) that—

21 (1) for discharges occurring during fiscal year
22 1999—

23 (A) received additional payments under
24 paragraph (5)(F) of such section (relating to

1 serving a significantly disproportionate number
 2 of low-income patients); and

3 (B) received no additional payments under
 4 paragraph (5)(B) of such section (relating to
 5 indirect costs of medical education); and

6 (2) is located in Fall River, Massachusetts, New
 7 Bedford, Massachusetts, or Wareham, Massachu-
 8 setts.

9 (c) CONSTRUCTION.—For purposes of such section
 10 1886(d), the reclassification under subsection (a) shall be
 11 treated as a decision of the Medicare Geographic Classi-
 12 fication Review Board under paragraph (10) of that sec-
 13 tion.

14 **TITLE II—PROVISIONS**
 15 **RELATING TO PART B**
 16 **Subtitle A—Hospital Outpatient**
 17 **Services**

18 **SEC. 201. REDUCTION OF EFFECTIVE HOPD COINSURANCE**

19 **RATE TO 20 PERCENT BY 2019.**

20 Section 1833(t)(3)(B)(ii) (42 U.S.C.
 21 1395l(t)(3)(B)(ii)) is amended—

22 (1) by striking “If the” and inserting:

23 “(I) IN GENERAL.—If the”; and

24 (2) by adding at the end the following new sub-
 25 clause:

1 “(II) ACCELERATED PHASE-IN.—
2 The Secretary shall estimate, prior to
3 January 1, 2002, the unadjusted co-
4 payment amount for each such service
5 (or groups of such services). If the
6 Secretary estimates such unadjusted
7 copayment amount to be greater than
8 20 percent for any such service (or
9 group of such services) on or after
10 January 1, 2019, the Secretary shall,
11 for services furnished beginning on or
12 after January 1, 2002, reduce the
13 unadjusted copayment amount for
14 such service (or group of such serv-
15 ices) in equal increments each year,
16 from the amount applicable in 2001,
17 by an amount estimated by the Sec-
18 retary such that the unadjusted co-
19 payment amount shall equal 20 per-
20 cent beginning on or after January 1,
21 2019.”.

1 **SEC. 202. APPLICATION OF TRANSITIONAL CORRIDOR TO**
 2 **CERTAIN HOSPITALS THAT DID NOT SUBMIT**
 3 **A 1996 COST REPORT.**

4 (a) IN GENERAL.—Section 1833(t)(7)(F)(ii)(I) (42
 5 U.S.C. 1395l(t)(7)(F)(ii)(I)) is amended by inserting “(or,
 6 in the case of a hospital that did not submit a cost report
 7 for such period, during the first cost reporting period end-
 8 ing in a year after 1996 and before 2001 for which the
 9 hospital submitted a cost report)” after “1996”.

10 (b) EFFECTIVE DATE.—The amendment made by
 11 subsection (a) shall take effect as if included in the enact-
 12 ment of section 202 of BBRA.

13 **SEC. 203. PERMANENT GUARANTEE OF PRE-BBA PAYMENT**
 14 **LEVELS FOR OUTPATIENT SERVICES FUR-**
 15 **NISHED BY CHILDREN’S HOSPITALS.**

16 (a) IN GENERAL.—Section 1833(t)(7)(D) (42 U.S.C.
 17 1395l(t)(7)(D)), as amended by section 432, is
 18 amended—

19 (1) in the heading, by inserting “, CHIL-
 20 DREN’S,” after “SMALL RURAL”; and

21 (2) by striking “section 1886(d)(1)(B)(v)” and
 22 inserting “clause (iii) or (v) of section
 23 1886(d)(1)(B)”.

24 (b) EFFECTIVE DATE.—The amendments made by
 25 subsection (a) shall apply to services provided on or after

1 the date that is 1 year after the date of enactment of this
 2 Act.

3 **Subtitle B—Provisions Relating to** 4 **Physicians**

5 **SEC. 211. LOAN DEFERMENT FOR RESIDENTS.**

6 (a) FAIRNESS IN MEDICAL STUDENT LOAN FINANC-
 7 ING.—

8 (1) ELIGIBILITY REQUIREMENTS.—Section
 9 427(a)(2)(C)(iii) of the Higher Education Act of
 10 1965 (20 U.S.C. 1077(a)(2)(C)(iii)) is amended by
 11 inserting before the semicolon the following: “, ex-
 12 cept that for a medical student such period shall not
 13 exceed the full initial residency period”.

14 (2) INSURANCE PROGRAM AGREEMENTS.—Sec-
 15 tion 428(b)(1)(M)(iii) of the Higher Education Act
 16 of 1965 (20 U.S.C. 1078(b)(1)(M)(iii)) is amended
 17 by inserting before the semicolon the following: “,
 18 except that for a medical student such period shall
 19 not exceed the full initial residency period”.

20 (3) DEFERMENT ELIGIBILITY.—Section
 21 455(f)(2)(C) of the Higher Education Act of 1965
 22 (20 U.S.C. 1087e(f)(2)(C)) is amended by inserting
 23 before the period the following: “, except that for a
 24 medical student such period shall not exceed the full
 25 initial residency period”.

1 (4) CONTENTS OF LOAN AGREEMENT.—Section
2 464(c)(2)(A)(iii) of the Higher Education Act of
3 1965 (20 U.S.C. 1087dd(c)(2)(A)(iii)) is amended
4 by inserting before the semicolon the following: “,
5 except that for a medical student such period shall
6 not exceed the full initial residency period”.

7 (b) FAIRNESS IN ECONOMIC HARDSHIP DETERMINA-
8 TION.—Section 435(o)(1)(B) of the Higher Education Act
9 of 1965 (20 U.S.C. 1085(o)(1)(B)) is amended to read
10 as follows:

11 “(B) such borrower is working full time
12 and has a Federal educational debt burden that
13 equals or exceeds 20 percent of such borrower’s
14 adjusted gross income, and the difference be-
15 tween such borrower’s adjusted gross income
16 minus such burden is less than 250 percent of
17 the greater of—

18 “(i) the annual earnings of an indi-
19 vidual earning the minimum wage under
20 section 6 of the Fair Labor Standards Act
21 of 1938; or

22 “(ii) the income official poverty line
23 (as defined by the Office of Management
24 and Budget, and revised annually in ac-
25 cordance with section 673(2) of the Com-

1 community Service Block Grant Act) applica-
2 ble to a family of 2; or”.

3 **SEC. 212. GAO STUDIES AND REPORTS ON MEDICARE PAY-**
4 **MENTS.**

5 (a) GAO STUDY ON HCFA POST-PAYMENT AUDIT
6 PROCESS.—

7 (1) STUDY.—The Comptroller General of the
8 United States shall conduct a study of the post-pay-
9 ment audit process under the medicare program
10 under title XVIII of the Social Security Act (42
11 U.S.C. 1395 et seq.) (in this section referred to as
12 the “medicare program”) as such process applies to
13 physicians, including the proper level of resources
14 that the Health Care Financing Administration
15 should devote to educating physicians regarding—

- 16 (A) coding and billing;
17 (B) documentation requirements; and
18 (C) the calculation of overpayments.

19 (2) REPORT.—Not later than 18 months after
20 the date of enactment of this Act, the Comptroller
21 General shall submit a report to the Secretary of
22 Health and Human Services and Congress on the
23 study conducted under paragraph (1) together with
24 specific recommendations for changes or improve-

1 ments in the post-payment audit process described
2 in such paragraph.

3 (b) GAO STUDY ON ADMINISTRATION AND OVER-
4 SIGHT.—

5 (1) STUDY.—The Comptroller General of the
6 United States shall conduct a study on the aggregate
7 effects of regulatory, audit, oversight, and paper-
8 work burdens on physicians and other health care
9 providers participating in the medicare program.

10 (2) REPORT.—Not later than 18 months after
11 the date of enactment of this Act, the Comptroller
12 General shall submit a report to the Secretary of
13 Health and Human Services and Congress on the
14 study conducted under paragraph (1) together with
15 recommendations regarding any area in which—

16 (A) a reduction in paperwork, an ease of
17 administration, or an appropriate change in
18 oversight and review may be accomplished; or

19 (B) additional payments or education are
20 needed to assist physicians and other health
21 care providers in understanding and complying
22 with any legal or regulatory requirements.

1 **SEC. 213. MEDPAC STUDY ON THE RESOURCE-BASED PRACTICE**
2 **EXPENSE SYSTEM.**

3 (a) STUDY.—The Medicare Payment Advisory Com-
4 mission established under section 1805 of the Social Secu-
5 rity Act (42 U.S.C. 1395b–6) (in this section referred to
6 as “MedPAC”) shall conduct a study of the refinements
7 to the practice expense relative value units during the
8 transition to a resource-based practice expense system for
9 physician payments under the medicare program under
10 title XVIII of the Social Security Act (42 U.S.C. 1395
11 et seq.) (in this section referred to as the “medicare pro-
12 gram”).

13 (b) REPORT.—Not later than July 1, 2001, MedPAC
14 shall submit a report to the Secretary of Health and
15 Human Services and Congress on the study conducted
16 under subsection (a) together with recommendations
17 regarding—

18 (1) any change or adjustment that is appro-
19 priate to ensure full access to a spectrum of care for
20 beneficiaries under the medicare program; and

21 (2) the appropriateness of payments to physi-
22 cians.

1 **Subtitle C—Ambulance Services**

2 **SEC. 221. ELECTION TO FOREGO PHASE-IN OF FEE SCHED-** 3 **ULE FOR AMBULANCE SERVICES.**

4 Section 1834(l) (42 U.S.C. 1395m(l)) is amended by
 5 adding at the end the following new paragraph:

6 “(8) ELECTION TO FOREGO PHASE-IN OF FEE
 7 SCHEDULE.—

8 “(A) IN GENERAL.—If the Secretary pro-
 9 vides for a phase-in of the fee schedule estab-
 10 lished under this subsection, a supplier of am-
 11 bulance services may make an election to re-
 12 ceive payments based only on such fee schedule
 13 at any time during such phase-in, and the Sec-
 14 retary shall begin to make payments to the sup-
 15 plier based only on such fee schedule not later
 16 than the date that is 60 days after the date on
 17 which the supplier notifies the Secretary of such
 18 election.

19 “(B) WAIVER OF BUDGET NEUTRALITY.—
 20 The Secretary shall apply paragraph (3)(A) as
 21 if this paragraph had not been enacted.”.

22 **SEC. 222. PRUDENT LAYPERSON STANDARD FOR EMER-** 23 **GENCY AMBULANCE SERVICES.**

24 (a) IN GENERAL.—Section 1861(s)(7) (42 U.S.C.
 25 1395x(s)(7)) is amended by inserting before the semicolon

1 at the end the following: “, except that such regulations
 2 shall not fail to treat ambulance services as medical and
 3 other health services solely because the ultimate diagnosis
 4 of the individual receiving the ambulance services results
 5 in a conclusion that ambulance services were not nec-
 6 essary, as long as the request for ambulance services is
 7 made after the sudden onset of a medical condition that
 8 would be classified as an emergency medical condition (as
 9 defined in section 1852(d)(3)(B)).”.

10 (b) EFFECTIVE DATE.—The amendment made by
 11 this section shall apply with respect to ambulance services
 12 provided on or after October 1, 2000.

13 **SEC. 223. ELIMINATION OF REDUCTION IN INFLATION AD-**
 14 **JUSTMENTS FOR AMBULANCE SERVICES.**

15 Subparagraphs (A) and (B) of section 1834(l)(3) (42
 16 U.S.C. 1395m(l)(3)(A)) are each amended by striking “re-
 17 duced in the case of 2001 and 2002 by 1.0 percentage
 18 points” and inserting “increased in the case of 2001 by
 19 1.0 percentage point”.

20 **SEC. 224. STUDY AND REPORT ON THE COSTS OF RURAL**
 21 **AMBULANCE SERVICES.**

22 (a) STUDY.—The Secretary of Health and Human
 23 Services (in this section referred to as the “Secretary”),
 24 in consultation with the Office of Rural Health Policy,
 25 shall conduct a study of the means by which rural areas

1 with low population densities can be identified for the pur-
 2 pose of designating areas in which the cost of providing
 3 ambulance services would be expected to be higher than
 4 similar services provided in more heavily populated areas
 5 because of low usage. Such study shall also include an
 6 analysis of the additional costs of providing ambulance
 7 services in areas designated under the previous sentence.

8 (b) REPORT.—Not later than June 30, 2001, the
 9 Secretary shall submit a report to Congress on the study
 10 conducted under subsection (a), together with a regulation
 11 based on that study which adjusts the fee schedule pay-
 12 ment rates for ambulance services provided in low density
 13 rural areas based on the increased cost of providing such
 14 services in such areas.

15 **SEC. 225. INTERIM PAYMENTS FOR RURAL GROUND AMBU-**
 16 **LANCE SERVICES UNTIL REGULATION IMPLE-**
 17 **MENTED.**

18 (a) INTERIM PAYMENTS.—Section 1834(l) (42
 19 U.S.C. 1395m(l)), as amended by section 221, is amended
 20 by adding at the end the following new paragraph:

21 “(9) INTERIM PAYMENTS FOR RURAL GROUND
 22 AMBULANCE SERVICES.—Until such time as the fee
 23 schedule established under this subsection is modi-
 24 fied by the regulation described in section 224(b) of
 25 the Medicare, Medicaid, and SCHIP Balanced

1 Budget Refinement Act of 2000, the amount of pay-
 2 ment under this subsection for ground ambulance
 3 services provided in a rural area (as defined in sec-
 4 tion 1886(d)(2)(D)) shall be the greater of—

5 “(A) the amount determined under the fee
 6 schedule established under this subsection
 7 (without regard to any phase-in established pur-
 8 suant to paragraph (2)(E)); or

9 “(B) the amount that would have been
 10 paid for such services if the amendments made
 11 by section 4531(b) of the Balanced Budget Act
 12 of 1997 had not been enacted;

13 as adjusted for inflation in the manner described in
 14 paragraph (3)(B). For purposes of this paragraph,
 15 an ambulance trip shall be considered to have been
 16 provided in a rural area only if the transportation of
 17 the patient originated in a rural area.”.

18 (b) CONFORMING AMENDMENTS.—Section
 19 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended—

20 (1) in subparagraph (R)—

21 (A) by inserting “except as provided in
 22 subparagraph (T),” before “with respect”; and

23 (B) by striking “and” at the end; and

24 (2) in subparagraph (S), by striking the semi-
 25 colon at the end and inserting “, and (T) with re-

1 spect to ambulance services described in section
2 1834(l)(9), the amount paid shall be 80 percent of
3 the lesser of the actual charge for the services or the
4 amount determined under such section;”.

5 (c) EFFECTIVE DATE.—The amendments made by
6 this section shall apply with respect to services provided
7 on and after January 1, 2001.

8 **SEC. 226. GAO STUDY AND REPORT ON THE COSTS OF**
9 **EMERGENCY AND MEDICAL TRANSPOR-**
10 **TATION SERVICES.**

11 (a) STUDY.—The Comptroller General of the United
12 States shall conduct a study of the costs of providing
13 emergency and medical transportation services across the
14 range of acuity levels of conditions for which such trans-
15 portation services are provided.

16 (b) REPORT.—Not later than 18 months after the
17 date of enactment of this Act, the Comptroller General
18 shall submit a report to the Secretary of Health and
19 Human Services and Congress on the study conducted
20 under subsection (a), together with recommendations for
21 any changes in methodology or payment level necessary
22 to fairly compensate suppliers of emergency and medical
23 transportation services and to ensure the access of bene-
24 ficiaries under the medicare program under title XVIII of

1 the Social Security Act (42 U.S.C. 1395 et seq.) to such
2 services.

3 **Subtitle D—Preventive Services**

4 **SEC. 231. ELIMINATION OF DEDUCTIBLES AND COINSUR-** 5 **ANCE FOR PREVENTIVE BENEFITS.**

6 (a) IN GENERAL.—Section 1833 (42 U.S.C. 1395l)
7 is amended by inserting after subsection (o) the following
8 new subsection:

9 “(p) DEDUCTIBLES AND COINSURANCE WAIVED FOR
10 PREVENTIVE BENEFITS.—The Secretary may not require
11 the payment of any deductible or coinsurance under sub-
12 section (a) or (b) of any individual enrolled for coverage
13 under this part for any of the following preventive health
14 care items and services:

15 “(1) Blood-testing strips, lancets, and blood
16 glucose monitors for individuals with diabetes de-
17 scribed in section 1861(n).

18 “(2) Diabetes outpatient self-management
19 training services (as defined in section 1861(qq)(1)).

20 “(3) Pneumococcal, influenza, and hepatitis B
21 vaccines and administration described in section
22 1861(s)(10).

23 “(4) Screening mammography (as defined in
24 section 1861(jj)).

1 “(5) Screening pap smear and screening pelvic
2 exam (as defined in paragraphs (1) and (2) of sec-
3 tion 1861(nn), respectively).

4 “(6) Bone mass measurement (as defined in
5 section 1861(rr)(1)).

6 “(7) Prostate cancer screening test (as defined
7 in section 1861(oo)(1)).

8 “(8) Colorectal cancer screening test (as de-
9 fined in section 1861(pp)(1)).”.

10 (b) WAIVER OF COINSURANCE.—Section
11 1833(a)(1)(B) (42 U.S.C. 1395l(a)(1)(B)) is amended to
12 read as follows: “(B) with respect to preventive health care
13 items and services described in subsection (p), the
14 amounts paid shall be 100 percent of the fee schedule or
15 other basis of payment under this title,”.

16 (c) WAIVER OF DEDUCTIBLE.—Section 1833(b)(1)
17 (42 U.S.C. 1395l(b)(1)) is amended to read as follows:
18 “(1) such deductible shall not apply with respect to pre-
19 ventive health care items and services described in sub-
20 section (p),”.

21 (d) ADDING “LANCET” TO DEFINITION OF DME.—
22 Section 1861(n) (42 U.S.C. 1395x(n)) is amended by
23 striking “blood-testing strips and blood glucose monitors”
24 and inserting “blood-testing strips, lancets, and blood glu-
25 cose monitors”.

1 (e) CONFORMING AMENDMENTS.—

2 (1) ELIMINATION OF COINSURANCE FOR CLIN-
 3 ICAL DIAGNOSTIC LABORATORY TESTS.—Paragraphs
 4 (1)(D)(i) and (2)(D)(i) of section 1833(a) (42
 5 U.S.C. 1395l(a)) are each amended—

6 (A) by striking “basis or which” and in-
 7 serting “basis, which”; and

8 (B) by inserting “, or which are described
 9 in subsection (p)” after “critical access hos-
 10 pital”.

11 (2) ELIMINATION OF COINSURANCE FOR CER-
 12 TAIN DME.—Section 1834(a)(1)(A) (42 U.S.C.
 13 1395m(a)(1)(A)) is amended by inserting “(or 100
 14 percent, in the case of such an item described in sec-
 15 tion 1833(p))” after “80 percent”.

16 (3) ELIMINATION OF COINSURANCE FOR
 17 SCREENING MAMMOGRAPHY.—Section 1834(c)(1)(C)
 18 (42 U.S.C. 1395m(c)(1)(C)) is amended by striking
 19 “80 percent” and inserting “100 percent”.

20 (4) ELIMINATION OF DEDUCTIBLES AND COIN-
 21 SURANCE FOR COLORECTAL CANCER SCREENING
 22 TESTS.—Section 1834(d) (42 U.S.C. 1395m(d)) is
 23 amended—

24 (A) in paragraph (2)(C)—

25 (i) by striking clause (ii);

1 (ii) by striking “FACILITY PAYMENT
 2 LIMIT.—” and all that follows through
 3 “Notwithstanding” and inserting “FACIL-
 4 ITY PAYMENT LIMIT.—Notwithstanding”;
 5 and

6 (iii) by redesignating subclauses (I)
 7 and (II) as clauses (i) and (ii), respec-
 8 tively; and

9 (B) in paragraph (3)(C)—

10 (i) by striking clause (ii); and

11 (ii) by striking “FACILITY PAYMENT
 12 LIMIT.—” and all that follows through
 13 “Notwithstanding” and inserting “FACIL-
 14 ITY PAYMENT LIMIT.—Notwithstanding”.

15 (f) EFFECTIVE DATE.—The amendments made by
 16 this section shall apply to items and services furnished on
 17 or after July 1, 2001.

18 **SEC. 232. COUNSELING FOR CESSATION OF TOBACCO USE.**

19 (a) COVERAGE.—Section 1861(s)(2) (42 U.S.C.
 20 1395x(s)(2)) is amended—

21 (1) in subparagraph (S), by striking “and” at
 22 the end;

23 (2) in subparagraph (T), by inserting “and” at
 24 the end; and

1 (3) by adding at the end the following new sub-
2 paragraph:

3 “(U) counseling for cessation of tobacco use (as
4 defined in subsection (uu)) for individuals who have
5 a history of tobacco use;”.

6 (b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C.
7 1395x) is amended by adding at the end the following new
8 subsection:

9 “Counseling for Cessation of Tobacco Use

10 “(uu)(1) Except as provided in paragraph (2), the
11 term ‘counseling for cessation of tobacco use’ means diag-
12 nostic, therapy, and counseling services for cessation of
13 tobacco use which are furnished—

14 “(A) by or under the supervision of a physician;
15 or

16 “(B) by any other health care professional who
17 is legally authorized to furnish such services under
18 State law (or the State regulatory mechanism pro-
19 vided by State law) of the State in which the serv-
20 ices are furnished, as would otherwise be covered if
21 furnished by a physician or as an incident to a phy-
22 sician’s professional service.

23 “(2) The term ‘counseling for cessation of tobacco
24 use’ does not include coverage for drugs or biologicals that
25 are not otherwise covered under this title.”.

1 (c) ELIMINATION OF COST-SHARING.—

2 (1) ELIMINATION OF COINSURANCE.—Section
3 1833(a)(1) (42 U.S.C. 1395l(a)(1)), as amended by
4 section 225(b), is amended—

5 (A) by striking “and” before “(T)”; and

6 (B) by inserting before the semicolon at
7 the end the following: “, and (U) with respect
8 to counseling for cessation of tobacco use (as
9 defined in section 1861(uu)), the amount paid
10 shall be 100 percent of the lesser of the actual
11 charge for the services or the amount deter-
12 mined by a fee schedule established by the Sec-
13 retary for the purposes of this subparagraph”.

14 (2) ELIMINATION OF DEDUCTIBLE.—The first
15 sentence of section 1833(b) (42 U.S.C. 1395l(b)) is
16 amended—

17 (A) by striking “and” before “(6)”; and

18 (B) by inserting before the period the fol-
19 lowing: “, and (7) such deductible shall not
20 apply with respect to counseling for cessation of
21 tobacco use (as defined in section 1861(uu))”.

22 (d) EFFECTIVE DATE.—The amendments made by
23 this section shall apply to services furnished on or after
24 July 1, 2001.

1 **SEC. 233. COVERAGE OF GLAUCOMA DETECTION TESTS.**

2 (a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x),
3 as amended by section 232, is amended—

4 (1) in subsection (s)(2)—

5 (A) in subparagraph (T), by striking
6 “and” at the end;

7 (B) in subparagraph (U), by inserting
8 “and” at the end; and

9 (C) by adding at the end the following new
10 subparagraph:

11 “(V) glaucoma detection tests (as defined in
12 subsection (vv));”; and

13 (2) by adding at the end the following new sub-
14 section:

15 “Glaucoma Detection Tests

16 “(vv) The term ‘glaucoma detection test’ means all
17 of the following conducted for the purpose of early detec-
18 tion of glaucoma:

19 “(1) A dilated eye examination with an intra-
20 ocular pressure measurement.

21 “(2) Direct ophthalmoscopy or slit-lamp bio-
22 microscopic examination.”.

23 (b) LIMITATION ON ELIGIBILITY AND FREQUENCY.—
24 Section 1834 (42 U.S.C. 1395m) is amended by adding
25 at the end the following new subsection:

1 “(m) LIMITATION ON COVERAGE OF GLAUCOMA DE-
2 TECTION TESTS.—

3 “(1) IN GENERAL.—Notwithstanding any other
4 provision of this part, with respect to expenses in-
5 curred for glaucoma detection tests (as defined in
6 section 1861(vv)), payment may be made only for
7 glaucoma detection tests conducted—

8 “(A) for individuals described in paragraph
9 (2); and

10 “(B) consistent with the frequency per-
11 mitted under paragraph (3).

12 “(2) INDIVIDUALS ELIGIBLE FOR BENEFIT.—
13 Individuals described in this paragraph are as fol-
14 lows:

15 “(A) Individuals who are 60 years of age
16 or older and who have a family history of glau-
17 coma.

18 “(B) Other individuals who are at high
19 risk (as determined by the Secretary) of devel-
20 oping glaucoma.

21 “(3) FREQUENCY LIMIT.—

22 “(A) IN GENERAL.—Subject to subpara-
23 graph (B), payment may not be made under
24 this part for a glaucoma detection test per-
25 formed for an individual within 23 months fol-

1 lowing the month in which a glaucoma detection
2 test was performed under this part for the indi-
3 vidual.

4 “(B) EXCEPTION.—The Secretary may
5 permit a glaucoma detection test to be covered
6 on a more frequent basis than that provided
7 under subparagraph (A) under such cir-
8 cumstances as the Secretary determines to be
9 appropriate.”.

10 (c) NO APPLICATION OF DEDUCTIBLE.—Section
11 1833(b)(5) (42 U.S.C. 1395l(b)(5)) is amended by insert-
12 ing “or with respect to glaucoma detection tests (as de-
13 fined in section 1861(vv))” after “1861(jj))”.

14 (d) CONFORMING AMENDMENTS.—Section 1862(a)
15 (42 U.S.C. 1395y(a)) is amended—

16 (1) in paragraph (1)—

17 (A) in subparagraph (H), by striking
18 “and” at the end;

19 (B) in subparagraph (I), by striking the
20 semicolon at the end and inserting “, and”; and

21 (C) by adding at the end the following new
22 subparagraph:

23 “(J) in the case of glaucoma detection tests (as
24 defined in section 1861(vv)), which are furnished to
25 an individual not described in paragraph (2) of sec-

1 tion 1834(m) or which are performed more fre-
 2 quently than is covered under paragraph (3) of such
 3 section;” and

4 (2) in paragraph (7), by striking “or (H)” and
 5 inserting “(H), or (I)”.

6 (e) EFFECTIVE DATE.—The amendments made by
 7 this section apply to tests provided on or after July 1,
 8 2001.

9 **SEC. 234. MEDICAL NUTRITION THERAPY SERVICES FOR**
 10 **BENEFICIARIES WITH DIABETES, A CARDIO-**
 11 **VASCULAR DISEASE, OR A RENAL DISEASE.**

12 (a) COVERAGE.—Section 1861(s)(2) (42 U.S.C.
 13 1395x(s)(2)), as amended by section 233(a), is amended—

14 (1) in subparagraph (U) by striking “and” at
 15 the end;

16 (2) in subparagraph (V) by inserting “and” at
 17 the end; and

18 (3) by adding at the end the following new sub-
 19 paragraph:

20 “(W) medical nutrition therapy services (as de-
 21 fined in subsection (ww)(1)) in the case of a bene-
 22 ficiary with diabetes, a cardiovascular disease (in-
 23 cluding congestive heart failure, arteriosclerosis,
 24 hyperlipidemia, hypertension, and
 25 hypercholesterolemia), or a renal disease;”.

1 (b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C.
2 1395x), as amended by section 233(a), is amended by add-
3 ing at the end the following new subsection:

4 “Medical Nutrition Therapy Services; Registered
5 Dietitian or Nutrition Professional

6 “(ww)(1) The term ‘medical nutrition therapy serv-
7 ices’ means nutritional diagnostic, therapy, and counseling
8 services for the purpose of disease management which are
9 furnished by a registered dietitian or nutrition profes-
10 sional (as defined in paragraph (2)) pursuant to a referral
11 by a physician (as defined in subsection (r)(1)).

12 “(2) Subject to paragraph (3), the term ‘registered
13 dietitian or nutrition professional’ means an individual
14 who—

15 “(A) holds a baccalaureate or higher degree
16 granted by a regionally accredited college or univer-
17 sity in the United States (or an equivalent foreign
18 degree) with completion of the academic require-
19 ments of a program in nutrition or dietetics, as ac-
20 credited by an appropriate national accreditation or-
21 ganization recognized by the Secretary for this pur-
22 pose;

23 “(B) has completed at least 900 hours of super-
24 vised dietetics practice under the supervision of a
25 registered dietitian or nutrition professional; and

1 “(C)(i) is licensed or certified as a dietitian or
2 nutrition professional by the State in which the serv-
3 ices are performed; or

4 “(ii) in the case of an individual in a State that
5 does not provide for such licensure or certification,
6 meets such other criteria as the Secretary estab-
7 lishes.

8 “(3) Subparagraphs (A) and (B) of paragraph (2)
9 shall not apply in the case of an individual who, as of the
10 date of enactment of this subsection, is licensed or cer-
11 tified as a dietitian or nutrition professional by the State
12 in which medical nutrition therapy services are per-
13 formed.”.

14 (c) PAYMENT.—Section 1833(a)(1) (42 U.S.C.
15 1395l(a)(1)), as amended by section 232(c)(1), is
16 amended—

17 (1) by striking “and” before “(U)”; and

18 (2) by inserting before the semicolon at the end
19 the following: “, and (V) with respect to medical nu-
20 trition therapy services (as defined in section
21 1861(w)), the amount paid shall be 85 percent of
22 the lesser of the actual charge for the services or the
23 amount determined under the fee schedule estab-
24 lished under section 1848(b) for the same services if
25 furnished by a physician”.

1 (d) EFFECTIVE DATE.—The amendments made by
2 this section apply to services furnished on or after July
3 1, 2001.

4 **SEC. 235. STUDIES ON PREVENTIVE INTERVENTIONS IN**
5 **PRIMARY CARE FOR OLDER AMERICANS.**

6 (a) STUDIES.—The Secretary of Health and Human
7 Services, acting through the United States Preventive
8 Services Task Force, shall conduct a series of studies de-
9 signed to identify preventive interventions that can be de-
10 livered in the primary care setting that are most valuable
11 to older Americans.

12 (b) MISSION STATEMENT.—The mission statement of
13 the United States Preventive Services Task Force is
14 amended to include the evaluation of services that are of
15 particular relevance to older Americans.

16 (c) REPORT.—Not later than 1 year after the date
17 of enactment of this Act, and annually thereafter, the Sec-
18 retary of Health and Human Services shall submit a re-
19 port to Congress on the conclusions of the studies con-
20 ducted under subsection (a), together with recommenda-
21 tions for such legislation and administrative actions as the
22 Secretary considers appropriate.

23 **SEC. 236. INSTITUTE OF MEDICINE 5-YEAR MEDICARE PRE-**
24 **VENTION BENEFIT STUDY AND REPORT.**

25 (a) STUDY.—

1 (1) IN GENERAL.—The Secretary of Health and
2 Human Services shall contract with the Institute of
3 Medicine of the National Academy of Sciences to
4 conduct a comprehensive study of current literature
5 and best practices in the field of health promotion
6 and disease prevention among medicare beneficiaries
7 including the issues described in paragraph (2) and
8 to submit the report described in subsection (b).

9 (2) ISSUES STUDIED.—The study required
10 under paragraph (1) shall include an assessment
11 of—

12 (A) whether each covered benefit is—

13 (i) medically effective; and

14 (ii) a cost-effective benefit or a cost-
15 saving benefit;

16 (B) utilization of covered benefits (includ-
17 ing any barriers to or incentives to increase uti-
18 lization); and

19 (C) quality of life issues associated with
20 both health promotion and disease prevention
21 benefits covered under the medicare program
22 and those that are not covered under such pro-
23 gram that would affect all medicare bene-
24 ficiaries.

25 (b) REPORT.—

1 (1) IN GENERAL.—Not later than 5 years after
2 the date of enactment of this section, and every fifth
3 year thereafter, the Institute of Medicine of the Na-
4 tional Academy of Sciences shall submit to the
5 President a report that contains a detailed state-
6 ment of the findings and conclusions of the study
7 conducted under subsection (a) and the rec-
8 ommendations for legislation described in paragraph
9 (2).

10 (2) RECOMMENDATIONS FOR LEGISLATION.—
11 The Institute of Medicine of the National Academy
12 of Sciences, in consultation with the Partnership for
13 Prevention, shall develop recommendations in legis-
14 lative form that—

15 (A) prioritize the preventive benefits under
16 the medicare program; and

17 (B) modify preventive benefits offered
18 under the medicare program based on the study
19 conducted under subsection (a).

20 (c) TRANSMISSION TO CONGRESS.—

21 (1) IN GENERAL.—On the day on which the re-
22 port described in subsection (b) is submitted to the
23 President, the President shall transmit the report
24 and recommendations in legislative form described in
25 subsection (b)(2) to Congress.

1 (2) DELIVERY.—Copies of the report and rec-
 2 ommendations in legislative form required to be
 3 transmitted to Congress under paragraph (1) shall
 4 be delivered—

5 (A) to both Houses of Congress on the
 6 same day;

7 (B) to the Clerk of the House of Rep-
 8 resentatives if the House is not in session; and

9 (C) to the Secretary of the Senate if the
 10 Senate is not in session.

11 (d) DEFINITIONS.—In this section:

12 (1) COST-EFFECTIVE BENEFIT.—The term
 13 “cost-effective benefit” means a benefit or technique
 14 that has—

15 (A) been subject to peer review;

16 (B) been described in scientific journals;
 17 and

18 (C) demonstrated value as measured by
 19 unit costs relative to health outcomes achieved.

20 (2) COST-SAVING BENEFIT.—The term “cost-
 21 saving benefit” means a benefit or technique that
 22 has—

23 (A) been subject to peer review;

24 (B) been described in scientific journals;
 25 and

1 (C) caused a net reduction in health care
2 costs for medicare beneficiaries.

3 (3) MEDICALLY EFFECTIVE.—The term “medi-
4 cally effective” means, with respect to a benefit or
5 technique, that the benefit or technique has been—

6 (A) subject to peer review;

7 (B) described in scientific journals; and

8 (C) determined to achieve an intended goal
9 under normal programmatic conditions.

10 (4) MEDICARE BENEFICIARY.—The term
11 “medicare beneficiary” means any individual who is
12 entitled to benefits under part A or enrolled under
13 part B of the medicare program, including any indi-
14 vidual enrolled in a Medicare+Choice plan offered
15 by a Medicare+Choice organization under part C of
16 such program.

17 (5) MEDICARE PROGRAM.—The term “medicare
18 program” means the health benefits program under
19 title XVIII of the Social Security Act (42 U.S.C.
20 1395 et seq.).

21 **SEC. 237. FAST-TRACK CONSIDERATION OF PREVENTION**
22 **BENEFIT LEGISLATION.**

23 (a) RULES OF HOUSE OF REPRESENTATIVES AND
24 SENATE.—This section is enacted by Congress—

1 (1) as an exercise of the rulemaking power of
2 the House of Representatives and the Senate, re-
3 spectively, and is deemed a part of the rules of each
4 House of Congress, but—

5 (A) is applicable only with respect to the
6 procedure to be followed in that House of Con-
7 gress in the case of an implementing bill (as de-
8 fined in subsection (d)); and

9 (B) supersedes other rules only to the ex-
10 tent that such rules are inconsistent with this
11 section; and

12 (2) with full recognition of the constitutional
13 right of either House of Congress to change the
14 rules (so far as relating to the procedure of that
15 House of Congress) at any time, in the same man-
16 ner and to the same extent as in the case of any
17 other rule of that House of Congress.

18 (b) INTRODUCTION AND REFERRAL.—

19 (1) INTRODUCTION.—

20 (A) IN GENERAL.—Subject to paragraph
21 (2), on the day on which the President trans-
22 mits the report pursuant to section 236(c) to
23 the House of Representatives and the Senate,
24 the recommendations in legislative form trans-
25 mitted by the President with respect to such re-

port shall be introduced as a bill (by request)
in the following manner:

(i) HOUSE OF REPRESENTATIVES.—In
the House of Representatives, by the Majority Leader, for himself and the Minority Leader, or by Members of the House of Representatives designated by the Majority Leader and Minority Leader.

(ii) SENATE.—In the Senate, by the Majority Leader, for himself and the Minority Leader, or by Members of the Senate designated by the Majority Leader and Minority Leader.

(B) SPECIAL RULE.—If either House of Congress is not in session on the day on which such recommendations in legislative form are transmitted, the recommendations in legislative form shall be introduced as a bill in that House of Congress, as provided in subparagraph (A), on the first day thereafter on which that House of Congress is in session.

(2) REFERRAL.—Such bills shall be referred by the presiding officers of the respective Houses to the appropriate committee, or, in the case of a bill containing provisions within the jurisdiction of 2 or

1 more committees, jointly to such committees for con-
2 sideration of those provisions within their respective
3 jurisdictions.

4 (c) CONSIDERATION.—After the recommendations in
5 legislative form have been introduced as a bill and referred
6 under subsection (b), such implementing bill shall be con-
7 sidered in the same manner as an implementing bill is con-
8 sidered under subsections (d), (e), (f), and (g) of section
9 151 of the Trade Act of 1974 (19 U.S.C. 2191).

10 (d) IMPLEMENTING BILL DEFINED.—In this section,
11 the term “implementing bill” means only the recommenda-
12 tions in legislative form of the Institute of Medicine of the
13 National Academy of Sciences described in section
14 236(b)(2), transmitted by the President to the House of
15 Representatives and the Senate under section 236(c), and
16 introduced and referred as provided in subsection (b) as
17 a bill of either House of Congress.

18 (e) COUNTING OF DAYS.—For purposes of this sec-
19 tion, any period of days referred to in section 151 of the
20 Trade Act of 1974 shall be computed by excluding—

21 (1) the days on which either House of Congress
22 is not in session because of an adjournment of more
23 than 3 days to a day certain or an adjournment of
24 Congress sine die; and

1 (2) any Saturday and Sunday, not excluded
 2 under paragraph (1), when either House is not in
 3 session.

4 **Subtitle E—Other Services**

5 **SEC. 241. REVISION OF MORATORIUM IN CAPS FOR THER-** 6 **APY SERVICES.**

7 (a) EXTENSION OF MORATORIUM.—Section
 8 1833(g)(4) (42 U.S.C. 1395l(g)(4)) is amended by strik-
 9 ing “during 2000 and 2001” and inserting “during the
 10 period beginning on January 1, 2000, and ending on the
 11 date that is 18 months after the date the Secretary sub-
 12 mits the report required under section 4541(d)(2) of the
 13 Balanced Budget Act of 1997 to Congress”.

14 (b) EXTENSION OF REPORTING DATE.—Section
 15 4541(d)(2) of BBA (42 U.S.C. 1395l note), as amended
 16 by section 221(c) of BBRA (113 Stat. 1501A–351), is
 17 amended by striking “January 1, 2001” and inserting
 18 “January 1, 2002”.

19 **SEC. 242. REVISION OF COVERAGE OF IMMUNO-** 20 **SUPPRESSIVE DRUGS.**

21 (a) REVISION.—

22 (1) IN GENERAL.—Section 1861(s)(2)(J) (42
 23 U.S.C. 1395x(s)(2)(J)) is amended to read as fol-
 24 lows:

1 “(J) prescription drugs used in immuno-
2 suppressive therapy furnished—

3 “(i) on or after the date of enactment of
4 the Medicare, Medicaid, and SCHIP Balanced
5 Budget Refinement Act of 2000 and before
6 January 1, 2004, to an individual who has re-
7 ceived an organ transplant; and

8 “(ii) on or after January 1, 2004, to an in-
9 dividual who receives an organ transplant for
10 which payment is made under this title, but
11 only in the case of drugs furnished within 36
12 months after the date of the transplant proce-
13 dure.”.

14 (2) CONFORMING AMENDMENTS.—

15 (A) EXTENDED COVERAGE.—Section 1832
16 (42 U.S.C. 1395k) is amended—

17 (i) by striking subsection (b); and

18 (ii) by redesignating subsection (c) as
19 subsection (b).

20 (B) PASS-THROUGH; REPORT.—Sub-
21 sections (c) and (d) of section 227 of BBRA
22 (113 Stat. 1501A–355) are repealed.

23 (3) EFFECTIVE DATE.—The amendments made
24 by this subsection shall apply to drugs furnished on
25 or after the date of enactment of this Act.

1 (b) EXTENSION OF CERTAIN SECONDARY PAYER RE-
 2 QUIREMENTS.—Section 1862(b)(1)(C) (42 U.S.C.
 3 1395y(b)(1)(C)) is amended by adding at the end the fol-
 4 lowing: “With regard to immunosuppressive drugs fur-
 5 nished on or after the date of enactment of the Medicare,
 6 Medicaid, and SCHIP Balanced Budget Refinement Act
 7 of 2000 and before January 1, 2004, this subparagraph
 8 shall be applied without regard to any time limitation.”.

9 **SEC. 243. STATE ACCREDITATION OF DIABETES SELF-MAN-**
 10 **AGEMENT TRAINING PROGRAMS.**

11 Section 1861(qq)(2) of the Social Security Act (42
 12 U.S.C. 1395xx(qq)(2)) is amended—

13 (1) in the matter preceding subparagraph (A),
 14 by striking “paragraph (1)—” and inserting “para-
 15 graph (1):”;

16 (2) in subparagraph (A)—

17 (A) by striking “a ‘certified provider’” and
 18 inserting “A ‘certified provider’”; and

19 (B) by striking “; and” and inserting a pe-
 20 riod; and

21 (3) in subparagraph (B)—

22 (A) by striking “a physician, or such other
 23 individual” and inserting “(i) A physician, or
 24 such other individual”;

1 (B) by inserting “(I)” before “meets appli-
2 cable standards”;

3 (C) by inserting “(II)” before “is recog-
4 nized”;

5 (D) by inserting “, or by a program de-
6 scribed in clause (ii),” after “recognized by an
7 organization that represents individuals (includ-
8 ing individuals under this title) with diabetes”;
9 and

10 (E) by adding at the end the following new
11 clause:

12 “(ii) Notwithstanding any reference to ‘a na-
13 tional accreditation body’ in section 1865(b), for
14 purposes of clause (i), a program described in this
15 clause is a program operated by a State for the pur-
16 poses of accrediting diabetes self-management train-
17 ing programs, if the Secretary determines that such
18 State program has established quality standards
19 that meet or exceed the standards established by the
20 Secretary under clause (i) or the standards origi-
21 nally established by the National Diabetes Advisory
22 Board and subsequently revised as described in
23 clause (i).”.

1 **SEC. 244. ELIMINATION OF REDUCTION IN PAYMENT**
 2 **AMOUNTS FOR DURABLE MEDICAL EQUIP-**
 3 **MENT AND OXYGEN AND OXYGEN EQUIP-**
 4 **MENT.**

5 (a) UPDATE FOR COVERED ITEMS.—Section
 6 1834(a)(14)(C) (42 U.S.C. 1395m(a)(14)(C)) is amended
 7 by striking “through 2002” and inserting “through
 8 2000”.

9 (b) ORTHOTICS AND PROSTHETICS.—Section
 10 1834(h)(4)(A)(v) (42 U.S.C. 1395m(h)(4)(A)(v)) is
 11 amended by striking “through 2002” and inserting
 12 “through 2000”.

13 (c) PARENTERAL AND ENTERAL NUTRIENTS, SUP-
 14 PLIES, AND EQUIPMENT.—Section 4551(b) of BBA (42
 15 U.S.C. 1395m note) is amended by striking “through
 16 2002” and inserting “through 2000”.

17 (d) OXYGEN AND OXYGEN EQUIPMENT.—Section
 18 1834(a)(9)(B) (42 U.S.C. 1395m(a)(9)(B)) is amended—

19 (1) in clause (v), by striking “and” at the end;

20 (2) in clause (vi)—

21 (A) by striking “each subsequent year”
 22 and inserting “2000”; and

23 (B) by striking the period at the end and
 24 inserting “; and”; and

25 (3) by adding at the end the following new
 26 clause:

1 “(vii) for 2001 and each subsequent
 2 year, the amount determined under this
 3 subparagraph for the preceding year in-
 4 creased by the covered item update for
 5 such subsequent year.”.

6 (e) CONFORMING AMENDMENT.—Section 228 of
 7 BBRA (113 Stat. 1501A–356) is repealed.

8 **SEC. 245. STANDARDS REGARDING PAYMENT FOR CERTAIN**
 9 **ORTHOTICS AND PROSTHETICS.**

10 (a) STANDARDS.—

11 (1) IN GENERAL.—Section 1834(h)(1) (42
 12 U.S.C. 1395m(h)(1)) is amended by adding at the
 13 end the following:

14 “(F) ESTABLISHMENT OF STANDARDS FOR
 15 CERTAIN ITEMS.—

16 “(i) IN GENERAL.—No payment shall
 17 be made for an applicable item unless such
 18 item is provided by a qualified practitioner
 19 or a qualified supplier under the system es-
 20 tablished by the Secretary under clause
 21 (iii). For purposes of the preceding sen-
 22 tence, if a qualified practitioner or a quali-
 23 fied supplier contracts with an entity to
 24 provide an applicable item, then no pay-

1 ment shall be made for such item unless
2 the entity is also a qualified supplier.

3 “(ii) DEFINITIONS.—In this
4 subparagraph—

5 “(I) APPLICABLE ITEM.—The
6 term ‘applicable item’ means orthotics
7 and prosthetics that require edu-
8 cation, training, and experience to
9 custom fabricate such item. Such
10 term does not include shoes and shoe
11 inserts.

12 “(II) QUALIFIED PRACTI-
13 TIONER.—The term ‘qualified practi-
14 tioner’ means a physician or health
15 professional who meets any of the fol-
16 lowing requirements:

17 “(aa) The physician or
18 health professional is specifically
19 trained and educated to provide
20 or manage the provision of cus-
21 tom-designed, fabricated, modi-
22 fied, and fitted orthotics and
23 prosthetics, and is either certified
24 by the American Board for Cer-
25 tification in Orthotics and Pros-

1 thetics, Inc., certified by the
2 Board for Orthotist/Prosthetist
3 Certification, or credentialed and
4 approved by a program that the
5 Secretary determines, in con-
6 sultation with appropriate ex-
7 perts in orthotics and prosthetics,
8 has training and education stand-
9 ards that are necessary to pro-
10 vide applicable items.

11 “(bb) The physician or
12 health professional is licensed in
13 orthotics or prosthetics by the
14 State in which the applicable
15 item is supplied, but only if the
16 Secretary determines that the
17 mechanisms used by the State to
18 provide such licensure meet
19 standards determined appropriate
20 by the Secretary.

21 “(cc) The physician or
22 health professional has completed
23 at least 10 years practice in the
24 provision of applicable items. A
25 physician or health professional

1 may not qualify as a qualified
2 practitioner under the preceding
3 sentence with respect to an appli-
4 cable item if the item was pro-
5 vided on or after January 1,
6 2005.

7 “(III) QUALIFIED SUPPLIER.—
8 The term ‘qualified supplier’ means
9 any entity that is—

10 “(aa) accredited by the
11 American Board for Certification
12 in Orthotics and Prosthetics, Inc.
13 or the Board for Orthotist/Pros-
14 thetist Certification; or

15 “(bb) accredited and ap-
16 proved by a program that the
17 Secretary determines has accredi-
18 tation and approval standards
19 that are essentially equivalent to
20 those of such Board.

21 “(iii) SYSTEM.—The Secretary, in
22 consultation with appropriate experts in
23 orthotics and prosthetics, shall establish a
24 system under which the Secretary shall—

1 “(I) determine which items are
2 applicable items and formulate a list
3 of such items;

4 “(II) review the applicable items
5 billed under the coding system estab-
6 lished under this title; and

7 “(III) limit payment for applica-
8 ble items pursuant to clause (i).”.

9 (2) EFFECTIVE DATE.—The amendment made
10 by paragraph (1) shall apply to items provided on or
11 after January 1, 2003.

12 (b) REVISION OF DEFINITION OF ORTHOTICS.—

13 (1) IN GENERAL.—Section 1861(s)(9) (42
14 U.S.C. 1395x(s)(9)) is amended by inserting “(in-
15 cluding such braces that are used in conjunction
16 with, or as components of, other medical or non-
17 medical equipment when provided by a qualified
18 practitioner (as defined in subclause (II) of section
19 1834(h)(1)(F))) or a qualified supplier (as defined
20 in subclause (III) of such section)” after “braces”.

21 (2) EFFECTIVE DATE.—The amendment made
22 by paragraph (1) shall apply to items provided on or
23 after January 1, 2003.

1 **SEC. 246. NATIONAL LIMITATION AMOUNT EQUAL TO 100**
 2 **PERCENT OF NATIONAL MEDIAN FOR NEW**
 3 **PAP SMEAR TECHNOLOGIES AND OTHER NEW**
 4 **CLINICAL LABORATORY TEST TECH-**
 5 **NOLOGIES.**

6 Section 1833(h)(4)(B)(viii) (42 U.S.C.
 7 1395l(h)(4)(B)(viii)) is amended by inserting before the
 8 period at the end the following: “(or 100 percent of such
 9 median in the case of a clinical diagnostic laboratory test
 10 performed on or after January 1, 2001, that the Secretary
 11 determines is a new test for which no limitation amount
 12 has previously been established under this subpara-
 13 graph)”.

14 **SEC. 247. INCREASED MEDICARE PAYMENTS FOR CER-**
 15 **TIFIED NURSE-MIDWIFE SERVICES.**

16 (a) AMOUNT OF PAYMENT.—Section 1833(a)(1)(K)
 17 (42 U.S.C. 1395l(a)(1)(K)) is amended by striking “65
 18 percent of the prevailing charge that would be allowed for
 19 the same service performed by a physician, or, for services
 20 furnished on or after January 1, 1992, 65 percent” and
 21 inserting “85 percent”.

22 (b) EFFECTIVE DATE.—The amendment made by
 23 subsection (a) shall apply to services furnished on or after
 24 January 1, 2001.

1 **SEC. 248. PAYMENT FOR ADMINISTRATION OF DRUGS.**

2 (a) REVIEW OF CHEMOTHERAPY ADMINISTRATION
3 PRACTICE EXPENSES RVUS.—The Secretary of Health
4 and Human Services shall review the resource-based prac-
5 tice expense component of relative value units under the
6 physician fee schedule under section 1848 of the Social
7 Security Act (42 U.S.C. 1395w–4) for chemotherapy ad-
8 ministration services to determine if such units should be
9 increased.

10 (b) MORE ACCURATE CHEMOTHERAPY DRUG PAY-
11 MENTS TIED TO INCREASES IN CHEMOTHERAPY ADMINIS-
12 TRATION PAYMENTS.—If the Secretary of Health and
13 Human Services determines, as a result of the review
14 under subsection (a), that the resource-based practice ex-
15 pense relative value units for chemotherapy administration
16 services should be increased, the Secretary—

17 (1) may implement such increases for such
18 services, but only if the Secretary simultaneously im-
19 plements more accurate average wholesale prices for
20 chemotherapy drugs (but in no case shall such si-
21 multaneous implementation occur prior to January
22 1, 2002); and

23 (2) if the Secretary implements such increases
24 for such services, shall do so without taking into ac-
25 count the requirement under the physician fee
26 schedule under section 1848(c)(2)(B)(ii)(II) of the

1 Social Security Act (42 U.S.C. 1395w–
2 4(c)(2)(B)(ii)(II)).

3 (c) BLOOD CLOTTING DRUG-RELATED ACTIVI-
4 TIES.—

5 (1) COVERAGE.—Section 1861(s)(2)(I) (42
6 U.S.C. 1395x(s)(2)(I)) is amended—

7 (A) by striking “and” after “supervision,”;
8 and

9 (B) by inserting the following before the
10 semicolon: “, and the costs (pursuant to section
11 1834(n)) incurred by suppliers of such factors”.

12 (2) PAYMENTS.—Section 1834 (42 U.S.C.
13 1395m), as amended by section 233(b), is amended
14 by adding at the end the following new subsection:
15 “(n) PAYMENT FOR BLOOD CLOTTING DRUG-RE-
16 LATED ACTIVITIES.—

17 “(1) IN GENERAL.—The Secretary shall make
18 payments in accordance with paragraph (2) to sup-
19 pliers of blood clotting factors (as described in sec-
20 tion 1861(s)(2)(I)) to cover the costs (such as ship-
21 ping, storage, inventory control, or other costs speci-
22 fied by the Secretary) incurred by such suppliers in
23 furnishing such factors to individuals enrolled under
24 this part.

1 “(2) PAYMENT AMOUNT.—The amount of pay-
 2 ment for furnishing such blood clotting factors (as
 3 so described) shall be an amount equal to 80 percent
 4 of the lesser of—

5 “(A) the actual charge for the furnishing
 6 of such factors; or

7 “(B) an amount equal to 10 cents (or such
 8 other amount determined appropriate by the
 9 Secretary) per unit of such factor furnished.”.

10 (3) EFFECTIVE DATE.—The amendments made
 11 by this subsection shall apply to blood clotting fac-
 12 tors (as described in section 1861(s)(2)(I) of the So-
 13 cial Security Act (42 U.S.C. 1395x(s)(2)(I))) fur-
 14 nished on or after the date that the Secretary of
 15 Health and Human Services implements more accu-
 16 rate average wholesale prices for such factors.

17 **SEC. 249. MEDPAC STUDY ON IN-HOME INFUSION THERAPY**
 18 **NURSING SERVICES.**

19 (a) STUDY.—The Medicare Payment Advisory Com-
 20 mission established under section 1805 of the Social Secu-
 21 rity Act (42 U.S.C. 1395b–6) (in this section referred to
 22 as “MedPAC”) shall conduct a study on the provision of
 23 in-home infusion therapy nursing services, including a re-
 24 view of any documentation of clinical efficacy for those

1 services and any costs associated with providing those
2 services.

3 (b) REPORT.—Not later than 18 months after the
4 date of enactment of this Act, MedPAC shall submit a
5 report to the Secretary of Health and Human Services and
6 Congress on the study and review conducted under sub-
7 section (a) together with recommendations regarding the
8 establishment of a payment methodology for in-home infu-
9 sion therapy nursing services that ensures the continuing
10 access of beneficiaries under the medicare program under
11 title XVIII of the Social Security Act (42 U.S.C. 1395
12 et seq.) to those services.

13 **SEC. 250. COVERAGE OF VISION REHABILITATION SERV-**
14 **ICES.**

15 (a) COVERAGE.—Section 1861(s)(2) (42 U.S.C.
16 1395x(s)(2)) is amended—

17 (1) by striking “and” at the end of subpara-
18 graph (S);

19 (2) by striking the period at the end of (T) and
20 inserting “; and”; and

21 (3) by adding at the end the following new sub-
22 paragraph:

23 “(U) vision rehabilitation services (as defined in
24 subsection (uu)(1)).”.

1 (b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C.
2 1395x), as amended by sections 232, 233(a), and 234(b),
3 is further amended by adding at the end the following new
4 subsection:

5 “Vision Rehabilitation Services; Vision Rehabilitation
6 Professional

7 “(xx)(1) The term ‘vision rehabilitation services’
8 means a program of restorative services (as determined
9 by the Secretary in regulations) furnished by a vision re-
10 habilitation professional (as defined in paragraph (2)) to
11 an individual diagnosed with a vision impairment (as de-
12 fined in paragraph (6)) to promote the independence and
13 safety of the individual notwithstanding such impairment,
14 such services furnished pursuant to a plan of care estab-
15 lished by a physician (as defined in paragraph (1) or (4)
16 of subsection (r)).

17 “(2) The term ‘vision rehabilitation professional’
18 means any of the following individuals:

19 “(A) An orientation and mobility specialist (as
20 defined in paragraph (3)).

21 “(B) A rehabilitation teacher (as defined in
22 paragraph (4)).

23 “(C) A low vision therapist (as defined in para-
24 graph (5)).

1 “(3)(A) The term ‘orientation and mobility specialist’
2 means an individual—

3 “(i) who holds a baccalaureate or higher degree
4 granted by a regionally accredited college or univer-
5 sity in the United States (or an equivalent foreign
6 degree) in rehabilitation, special education, or a
7 health field with a university-based program of study
8 and clinical experience in orientation and mobility
9 (as defined in subparagraph (B)); and

10 “(ii)(I) who is licensed or certified as an ori-
11 entation and mobility specialist by the State in
12 which the orientation and mobility services are per-
13 formed; or

14 “(II) in the case of an individual furnishing ori-
15 entation and mobility services in a State which does
16 not provide for licensure or certification—

17 “(aa) who has successfully completed 350
18 hours of clinical practicum under the super-
19 vision of an orientation and mobility specialist
20 holding a master’s degree or higher, and who
21 has furnished not less than 9 months of super-
22 vised full-time orientation and mobility services
23 after obtaining a degree described in clause (i);
24 and

1 “(bb) who has successfully completed a na-
2 tional examination in orientation and mobility
3 administered by a national organization specifi-
4 cally dedicated to performing credentialing of
5 orientation and mobility specialists that is rec-
6 ognized by the Secretary, and who meets such
7 other criteria as the Secretary establishes.

8 “(B) The term ‘orientation and mobility’ means the
9 following services:

10 “(i) Assessment of needs of an individual who
11 has a vision impairment for skills training in meth-
12 ods of safe movement and in strategies to gather re-
13 quired environmental and spatial information.

14 “(ii) Development of appropriate integrated
15 service plans tailored to meet such needs identified
16 pursuant to an assessment under clause (i).

17 “(iii) Provision of training in and utilization
18 of—

19 “(I) equipment and adaptive devices in-
20 tended and designed for use by such an indi-
21 vidual; and

22 “(II) specialized techniques adapted for
23 such individuals, including orientation, sensory
24 development, systems of safe movement (includ-
25 ing long cane techniques), resource identifica-

1 tion, professional referrals (as appropriate),
2 and, in applied settings reinforcing instruction
3 for the use of optical devices as prescribed by
4 optometrists and ophthalmologists.

5 “(iv) Evaluation of the progress in performance
6 of such an individual receiving training under clause
7 (iii).

8 “(4)(A) The term ‘rehabilitation teacher’ means an
9 individual—

10 “(i) who holds a baccalaureate or higher degree
11 granted by a regionally accredited college or univer-
12 sity in the United States (or an equivalent foreign
13 degree) in rehabilitation, special education, or a
14 health field with a university-based program of study
15 and clinical experience in rehabilitation teaching (as
16 defined in subparagraph (B)); and

17 “(ii)(I) who is licensed or certified as a rehabili-
18 tation teacher by the State in which the rehabilita-
19 tion teaching services are performed; or

20 “(II) in the case of an individual furnishing re-
21 habilitation teaching services in a State which does
22 not provide for licensure or certification—

23 “(aa) who has successfully completed 350
24 hours of clinical practicum under the super-
25 vision of a rehabilitation teacher holding a mas-

1 ter’s degree or higher, and who has furnished
2 not less than 9 months of supervised full-time
3 rehabilitation teaching services after obtaining a
4 degree described in clause (i); and

5 “(bb) who has successfully completed a na-
6 tional examination in rehabilitation teaching ad-
7 ministered by a national organization specifi-
8 cally dedicated to performing credentialing of
9 rehabilitation teachers that is recognized by the
10 Secretary, and who meets such other criteria as
11 the Secretary establishes.

12 “(B) The term ‘rehabilitation teaching’ means the
13 following services:

14 “(i) Assessment of needs of an individual with
15 a vision impairment for skills training in inde-
16 pendent living and communications.

17 “(ii) Development of appropriate integrated
18 service plans tailored to meet such needs identified
19 pursuant to an assessment under clause (i).

20 “(iii) Provision of training in, and utilization
21 of—

22 “(I) equipment and adaptive devices in-
23 tended and designed for use by such an indi-
24 vidual, including, in applied settings, reinforcing
25 instruction for the use of optical devices as pre-

1 scribed by optometrists or ophthalmologists;
2 and

3 “(II) specialized techniques adapted for
4 such an individual, including braille and other
5 communication skills, personal self-care skills,
6 and home management skills.

7 “(iv) Evaluation of the progress in performance
8 of such an individual receiving training under clause
9 (iii).

10 “(5)(A) The term ‘low vision therapist’ means an
11 individual—

12 “(i) who holds—

13 “(I) a baccalaureate or higher degree
14 granted by a regionally accredited college or
15 university in the United States (or an equiva-
16 lent foreign degree) in rehabilitation, special
17 education, or a health field with a university-
18 based program of study and clinical experience
19 in orientation and mobility, rehabilitation teach-
20 ing, or teaching the visually impaired;

21 “(II) a master’s of science degree granted
22 by a regionally accredited college or university
23 in the United States (or an equivalent foreign
24 degree) in low vision rehabilitation; or

1 “(III) a baccalaureate or higher degree
2 granted by a regionally accredited college or
3 university in the United States (or an equiva-
4 lent foreign degree) in occupational therapy;

5 “(ii) who after obtaining a degree described in
6 clause (i) has performed at least 2 years of low vi-
7 sion therapy (as defined in subparagraph (B)) under
8 the supervision of an optometrist or ophthalmologist
9 in an appropriate setting (as determined by the Sec-
10 retary); and

11 “(iii)(I) who is licensed or certified as a low vi-
12 sion therapist by the State in which the services are
13 performed; or

14 “(II) in the case of an individual in a State
15 which does not provide for licensure or certification,
16 who has successfully completed a national examina-
17 tion in low vision therapy administered by a national
18 organization specifically dedicated to performing
19 credentialing of low vision therapists that is recog-
20 nized by the Secretary, and who meets such other
21 criteria as the Secretary establishes.

22 “(B) The term ‘low vision therapy’ means the fol-
23 lowing services furnished to an individual and based upon
24 the clinical findings of a low vision examination conducted
25 on the individual by an optometrist or an ophthalmologist:

1 “(i) Assessment of the performance of an indi-
2 vidual diagnosed with a vision impairment with pre-
3 scribed optical and adaptive nonoptical devices.

4 “(ii) In order to promote safety and maximize
5 use of visual ability of the individual diagnosed with
6 vision impairment, the provision of training in and
7 use of the following:

8 “(I) Visual abilities in daily living and
9 other tasks.

10 “(II) Optical devices prescribed by an op-
11 tometrist or ophthalmologist.

12 “(III) Adaptive non-optical and electronic
13 devices.

14 “(IV) Environmental cues and modifica-
15 tions.

16 “(iii) Evaluation of the progress in performance
17 of such an individual receiving the training and use
18 under clause (ii).

19 “(6)(A) The term ‘vision impairment’ means that an
20 individual is blind or partially sighted.

21 “(B) The term ‘blind’ means blind within the mean-
22 ing of ‘blindness’ as that term is defined in section
23 216(i)(1).

24 “(C) The term ‘partially sighted’ means functional vi-
25 sion impairment that constitutes a significant limitation

1 of visual capability resulting from disease, trauma, or con-
 2 genital or degenerative condition, that cannot be fully
 3 ameliorated by standard refractive correction, medication,
 4 or surgery, and that is manifested by one or more of the
 5 following:

6 “(i) Insufficient visual resolution.

7 “(ii) Inadequate field of vision.

8 “(iii) Reduced peak contrast sensitivity.”.

9 (c) PAYMENT.—Section 1833(a)(1) (42 U.S.C.
 10 1395l(a)(1)) is amended—

11 (1) by striking “and” before “(S)”; and

12 (2) by inserting before the semicolon at the end
 13 the following: “, and (T) with respect to vision reha-
 14 bilitation services (as defined in section 1861(xx))
 15 furnished by a vision rehabilitation professional, the
 16 amount paid shall be 80 percent of the lesser of the
 17 actual charge for the services or 85 percent of the
 18 amount determined under the fee schedule estab-
 19 lished under section 1848(b) for the same services if
 20 furnished by a physician”.

21 (d) EFFECTIVE DATE.—The amendments made by
 22 this section shall apply to services furnished on or after
 23 the date of the enactment of this Act.

24 (e) CONSULTATION.—The Secretary shall consult
 25 with the National Vision Rehabilitation Cooperative, the

1 Association for Education and Rehabilitation of the Blind
 2 and Visually Impaired, the Academy for Certification of
 3 Vision Rehabilitation and Education Professionals, and
 4 such other qualified professional and consumer organiza-
 5 tions as the Secretary determines appropriate in promul-
 6 gating regulations to carry out this Act.

7 **SEC. 251. LIMITING MEDICARE LATE ENROLLMENT PEN-**
 8 **ALTY TO 10 PERCENT AND TWICE THE PE-**
 9 **RIOD OF NO ENROLLMENT.**

10 (a) IN GENERAL.—The first sentence of section
 11 1839(b) (42 U.S.C. 1395r(b)) is amended by striking “10
 12 percent of the monthly premium so determined for each
 13 full 10 months” and inserting “10 percent of the monthly
 14 premium so determined for premiums paid during a period
 15 equal to twice the number of months in each of the full
 16 periods of 12 months”.

17 (b) CONFORMING AMENDMENTS.—

18 (1) Section 1818(c) (42 U.S.C. 1395i–2(c)) is
 19 amended—

20 (A) by striking paragraph (6); and

21 (B) by redesignating paragraphs (7)
 22 through (9) as paragraphs (6) through (8), re-
 23 spectively.

24 (2) Section 1818(g)(2)(B) (42 U.S.C. 1395i–
 25 2(g)(2)(B)) is amended by striking “by sub-

stituting” and all that follows and inserting the following: “by substituting ‘section 1818 (without any increase resulting from the application of section 1839(b) to such section)’ for ‘section 1839 (without any increase under subsection (b) thereof)’.”.

(c) EFFECTIVE DATE.—

(1) The amendments made by this section shall apply to premiums paid for months beginning after the end of the 90-day period beginning on the date of the enactment of this Act.

(2) In applying these amendments, months (before, during, or after the month in which this Act is enacted) in which an individual was or is required to pay an increased premium shall be taken into account in determining the month in which the premium will no longer be subject to an increase.

TITLE III—PROVISIONS RELATING TO PARTS A AND B Subtitle A—Home Health Services

SEC. 301. ELIMINATION OF 15 PERCENT REDUCTION IN PAYMENT RATES UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1895(b)(3)(A) (42 U.S.C. 1395fff(b)(3)(A)) is amended to read as follows:

1 “(A) INITIAL BASIS.—Under such system
2 the Secretary shall provide for computation of
3 a standard prospective payment amount (or
4 amounts). Such amount (or amounts) shall ini-
5 tially be based on the most current audited cost
6 report data available to the Secretary and shall
7 be computed in a manner so that the total
8 amounts payable under the system for the 12-
9 month period beginning on the date the Sec-
10 retary implements the system shall be equal to
11 the total amount that would have been made if
12 the system had not been in effect and if section
13 1861(v)(1)(L)(ix) had not been enacted. Each
14 such amount shall be standardized in a manner
15 that eliminates the effect of variations in rel-
16 ative case mix and area wage adjustments
17 among different home health agencies in a
18 budget neutral manner consistent with the case
19 mix and wage level adjustments provided under
20 paragraph (4)(A). Under the system, the Sec-
21 retary may recognize regional differences or dif-
22 ferences based upon whether or not the services
23 or agency are in an urbanized area.”.

1 (b) EFFECTIVE DATE.—The amendment made by
2 subsection (a) shall take effect as if included in the enact-
3 ment of BBRA.

4 **SEC. 302. ADDITIONAL PAYMENTS FOR OUTLIERS.**

5 (a) IN GENERAL.—Section 1895(b)(5) (42 U.S.C.
6 1395fff(b)(5)) is amended—

7 (1) by striking “OUTLIERS.—The Secretary”
8 and inserting the following (and conforming the in-
9 dentation of the succeeding matter accordingly):
10 “OUTLIERS.—

11 “(A) IN GENERAL.—The Secretary”; and

12 (2) by adding at the end the following new sub-
13 paragraph:

14 “(B) TEMPORARY ADDITIONAL PAYMENTS
15 FOR OUTLIERS.—For the purposes described in
16 the first sentence of subparagraph (A), there
17 are authorized to be appropriated from the
18 trust funds (as defined in section 1896(a)(8))
19 in appropriate part, as determined by the Sec-
20 retary, for each of fiscal years 2001 through
21 2005 an amount equal to \$500,000,000. Such
22 amounts shall be in addition to amounts avail-
23 able for payment under this section and shall
24 not result in a reduction of the standard pro-
25 spective payment amount (or amounts). In

1 making payments under this subparagraph, the
 2 Secretary shall use a loss-sharing ratio of 90
 3 percent.”.

4 (b) CONFORMING AMENDMENT.—Section
 5 1895(b)(3)(C) (42 U.S.C. 1395fff(b)(3)(C)) is amended
 6 by striking “paragraph (5)” and inserting “paragraph
 7 (5)(A)”.

8 **SEC. 303. ADDITIONAL PAYMENTS UNDER THE PROSPEC-**
 9 **TIVE PAYMENT SYSTEM FOR SERVICES FUR-**
 10 **NISHED IN RURAL AREAS AND SECURITY**
 11 **SERVICES.**

12 (a) INCREASE IN PAYMENT RATES FOR RURAL
 13 AGENCIES.—Section 1895(b) (42 U.S.C. 1395fff(b)) is
 14 amended by adding at the end the following new para-
 15 graph:

16 “(7) ADDITIONAL PAYMENT AMOUNT FOR
 17 SERVICES FURNISHED IN RURAL AREAS.—In the
 18 case of home health services furnished in a rural
 19 area (as defined in section 1886(d)(2)(D)), notwith-
 20 standing any other provision of this subsection, the
 21 amount of payment for such services is equal to 110
 22 percent of the payment amount otherwise made
 23 under this section (but for this paragraph) for serv-
 24 ices furnished in a rural area.”.

1 (b) ADDITIONAL PAYMENT FOR SECURITY SERV-
2 ICES.—Section 1895(b) (42 U.S.C. 1395fff(b)(3)), as
3 amended by subsection (a), is further amended by adding
4 at the end the following paragraph:

5 “(8) ADDITIONAL PAYMENT FOR SECURITY
6 SERVICES.—The Secretary shall provide for an addi-
7 tion or adjustment to the payment amount otherwise
8 made under this section for the reasonable cost (as
9 defined in section 1861(v)(1)(A)) of furnishing pro-
10 tective services to individuals furnishing home health
11 services under this title in areas where such individ-
12 uals are at risk of physical harm, as determined by
13 the Secretary.”.

14 (c) INAPPLICABILITY OF ADJUSTMENTS FOR BUDG-
15 ET NEUTRALITY.—Section 1895(b)(3) (42 U.S.C.
16 1395fff(b)(3)) is amended by adding at the end the fol-
17 lowing new subparagraph:

18 “(D) NO ADJUSTMENT FOR ADDITIONAL
19 PAYMENTS FOR RURAL SERVICES AND SECUR-
20 ITY SERVICES.—The Secretary shall not re-
21 duce the standard prospective payment amount
22 (or amounts) under this paragraph applicable
23 to home health services furnished during a pe-
24 riod to offset the increase in payments resulting
25 from the application of paragraph (7) (relating

1 to services furnished in rural areas) and para-
 2 graph (8) (relating to costs of security serv-
 3 ices).”.

4 (d) EFFECTIVE DATE.—The amendments made by
 5 this section apply with respect to items and services fur-
 6 nished on or after October 1, 2000.

7 **SEC. 304. EXCLUSION OF CERTAIN NONROUTINE MEDICAL**
 8 **SUPPLIES UNDER THE PPS FOR HOME**
 9 **HEALTH SERVICES.**

10 (a) EXCLUSION.—

11 (1) IN GENERAL.—Section 1895 (42 U.S.C.
 12 1395fff) is amended by adding at the end the fol-
 13 lowing new subsection:

14 “(e) EXCLUSION OF NONROUTINE MEDICAL SUP-
 15 PLIES.—

16 “(1) IN GENERAL.—Notwithstanding the pre-
 17 ceding provisions of this section, in the case of all
 18 nonroutine medical supplies (as defined by the Sec-
 19 retary) furnished by a home health agency during a
 20 year (beginning with 2001) for which payment is
 21 otherwise made on the basis of the prospective pay-
 22 ment amount under this section, payment under this
 23 section shall be based instead on the lesser of—

24 “(A) the actual charge for the nonroutine
 25 medical supply; or

1 “(B) the amount determined under the fee
 2 schedule established by the Secretary for pur-
 3 poses of making payment for such items under
 4 part B for nonroutine medical supplies fur-
 5 nished during that year.

6 “(2) BUDGET NEUTRALITY ADJUSTMENT.—The
 7 Secretary shall provide for an appropriate propor-
 8 tional reduction in payments under this section so
 9 that beginning with fiscal year 2001, the aggregate
 10 amount of such reductions is equal to the aggregate
 11 increase in payments attributable to the exclusion ef-
 12 fected under paragraph (1).”.

13 (2) CONFORMING AMENDMENT.—Section
 14 1895(b)(1) (42 U.S.C. 1395fff(b)(1)) is amended by
 15 striking “The Secretary” and inserting “Subject to
 16 subsection (e), the Secretary”.

17 (3) EFFECTIVE DATE.—The amendments made
 18 by this subsection shall apply to supplies furnished
 19 on or after January 1, 2001.

20 (b) EXCLUSION FROM CONSOLIDATED BILLING.—

21 (1) IN GENERAL.—For items provided during
 22 the applicable period, the Secretary of Health and
 23 Human Services shall administer the medicare pro-
 24 gram under title XVIII of the Social Security Act
 25 (42 U.S.C. 1395 et seq.) as if—

1 (A) section 1842(b)(6)(F) of such Act (42
2 U.S.C. 1395u(b)(6)(F)) was amended by strik-
3 ing “(including medical supplies described in
4 section 1861(m)(5), but excluding durable med-
5 ical equipment to the extent provided for in
6 such section)” and inserting “(excluding med-
7 ical supplies and durable medical equipment de-
8 scribed in section 1861(m)(5))”; and

9 (B) section 1862(a)(21) of such Act (42
10 U.S.C. 1395y(a)(21)) was amended by striking
11 “(including medical supplies described in sec-
12 tion 1861(m)(5), but excluding durable medical
13 equipment to the extent provided for in such
14 section)” and inserting “(excluding medical
15 supplies and durable medical equipment de-
16 scribed in section 1861(m)(5))”.

17 (2) APPLICABLE PERIOD DEFINED.—For pur-
18 poses of paragraph (1), the term “applicable period”
19 means the period beginning on January 1, 2001,
20 and ending on the later of—

21 (A) the date that is 18 months after the
22 date of enactment of this Act; or

23 (B) the date determined appropriate by the
24 Secretary of Health and Human Services.

1 (c) STUDY ON EXCLUSION OF CERTAIN NONROUTINE
2 MEDICAL SUPPLIES UNDER THE PPS FOR HOME
3 HEALTH SERVICES.—

4 (1) STUDY.—The Secretary of Health and
5 Human Services (in this subsection referred to as
6 the “Secretary”) shall conduct a study to identify
7 any nonroutine medical supply that may be appro-
8 priately and cost-effectively excluded from the pro-
9 spective payment system for home health services
10 under section 1895 of the Social Security Act (42
11 U.S.C. 1395fff). Specifically, the Secretary shall
12 consider whether wound care and ostomy supplies
13 should be excluded from such prospective payment
14 system.

15 (2) REPORT.—Not later than 18 months after
16 the date of enactment of this Act, the Secretary
17 shall submit to the committees of jurisdiction of the
18 House of Representatives and the Senate a report on
19 the study conducted under paragraph (1), including
20 a list of any nonroutine medical supplies that should
21 be excluded from the prospective payment system for
22 home health services under section 1895 of the So-
23 cial Security Act (42 U.S.C. 1395fff).

24 (d) EXCLUSION OF OTHER NONROUTINE MEDICAL
25 SUPPLIES.—Upon submission of the report under sub-

1 section (c)(2), the Secretary shall (if necessary) revise the
2 definition of nonroutine medical supply, as defined for
3 purposes of section 1895(e) (as added by subsection (a)),
4 based on the list of nonroutine medical supplies included
5 in such report.

6 **SEC. 305. CLARIFICATION OF THE HOMEBOUND DEFINI-**
7 **TION FOR THE HOME HEALTH BENEFIT.**

8 (a) IN GENERAL.—Sections 1814(a) and 1835(a) (42
9 U.S.C. 1395f(a) and 1395n(a)) are each amended—

10 (1) in the last sentence, by striking “, and that
11 absences of the individual from home are infrequent
12 or of relatively short duration, or are attributable to
13 the need to receive medical treatment”; and

14 (2) by adding at the end the following new sen-
15 tences: “Any absence of an individual from the home
16 attributable to the need to receive health care treat-
17 ment, including regular absences for the purpose of
18 participating for therapeutic, psychosocial, or med-
19 ical treatment in an adult day-care program that is
20 licensed or certified by a State, or accredited to fur-
21 nish adult day-care services in the State shall not
22 disqualify an individual from being considered to be
23 ‘confined to his home’. Any other absence of an indi-
24 vidual from the home shall not so disqualify an indi-
25 vidual if the absence is of infrequent or short dura-

1 tion. For purposes of the preceding sentence, any
2 absence for the purpose of visiting a family member
3 who is unable to visit the individual or for the pur-
4 pose of attending a religious service shall be deemed
5 to be an absence of infrequent and short duration.”.

6 (b) EFFECTIVE DATE.—The amendments made by
7 subsection (a) shall apply to items and services provided
8 on or after the date of enactment of this Act.

9 **SEC. 306. STANDARDS FOR HOME HEALTH BRANCH OF-**
10 **FICES.**

11 (a) IN GENERAL.—Section 1861(o) (42 U.S.C.
12 1395x(o)) is amended by adding at the end the following
13 new sentences: “For purposes of this subsection, a home
14 health agency may provide services through a single site
15 or through a branch office. For purposes of the preceding
16 sentence, the term ‘branch office’ means a service site for
17 home health services that is controlled and supervised by
18 a home health agency.”.

19 (b) ESTABLISHMENT OF STANDARDS.—

20 (1) IN GENERAL.—The Secretary of Health and
21 Human Services (in this subsection referred to as
22 the “Secretary”) shall establish, using a negotiated
23 rulemaking process under subchapter III of chapter
24 5 of title 5, United States Code, standards for the
25 operation of a branch office (as defined in the last

1 sentence of section 1861(o) of the Social Security
 2 Act (42 U.S.C. 1395x(o)), as added by subsection
 3 (a)).

4 (2) REQUIREMENTS.—In establishing standards
 5 under paragraph (1), the Secretary shall—

6 (A) provide for the special treatment of
 7 any home health agency or branch office—

8 (i) that is located in a frontier area;

9 or

10 (ii) with any other special cir-
 11 cumstance that the Secretary determines is
 12 appropriate; and

13 (B) allow the use of technology used by the
 14 home health agency to supervise the branch of-
 15 fice.

16 (3) CONSULTATION.—The Secretary shall es-
 17 tablish the regulations under this subsection in con-
 18 sultation with representatives of the home health in-
 19 dustry.

20 **SEC. 307. TREATMENT OF HOME HEALTH SERVICES PRO-**
 21 **VIDED IN CERTAIN COUNTIES.**

22 (a) IN GENERAL.—Notwithstanding any other provi-
 23 sion of law, effective for home health services provided
 24 under the prospective payment system under section 1895
 25 of the Social Security Act (42 U.S.C. 1395fff) during fis-

1 cal year 2001 in an applicable county, the geographic ad-
 2 justment factors applicable in such year to hospitals phys-
 3 ically located in such county under section 1886(d) of such
 4 Act (42 U.S.C. 1395ww(d)) (including the factors applica-
 5 ble to such hospitals by reason of any reclassification or
 6 deemed reclassification) shall be deemed to apply to such
 7 services instead of the area wage adjustment factors that
 8 would otherwise be applicable to such services under sec-
 9 tion 1895(b)(4)(C) of such Act (42 U.S.C.
 10 1395fff(b)(4)(C)).

11 (b) APPLICABLE COUNTY DEFINED.—For purposes
 12 of subsection (a), the term “applicable county” means any
 13 of the following counties:

- 14 (1) Dutchess County, New York.
- 15 (2) Orange County, New York.
- 16 (3) Clinton County, New York.
- 17 (4) Ulster County, New York.
- 18 (5) Otsego County, New York.
- 19 (6) Cayuga County, New York.
- 20 (7) St. Jefferson County, New York.

21 **SEC. 308. RULE OF CONSTRUCTION RELATING TO**
 22 **TELEHOMEHEALTH SERVICES.**

23 (a) IN GENERAL.—Section 1895(b) (42 U.S.C.
 24 1395fff(b)(3)), as amended by section 3, is further amend-
 25 ed by adding at the end the following paragraph:

1 “(9) RULE OF CONSTRUCTION RELATING TO
2 TELEHOMEHEALTH SERVICES.—

3 “(A) IN GENERAL.—Nothing in this sec-
4 tion, or in section 4206(a) of the Balanced
5 Budget Act of 1997 (42 U.S.C. 1395l note),
6 shall be construed as preventing a home health
7 agency receiving payment under this section
8 from furnishing a home health service via a
9 telecommunications system. Each home health
10 agency that submits a cost report to the Sec-
11 retary under this section shall include, in such
12 cost report, data with respect to the costs in-
13 curred in furnishing home health services to
14 medicare beneficiaries via such telecommuni-
15 cations systems.

16 “(B) LIMITATION.—The Secretary shall
17 not consider a home health service provided in
18 the manner described in subparagraph (A) to
19 be a home health visit for purposes of—

20 “(i) determining the amount of pay-
21 ment to be made under this section; or

22 “(ii) any requirement relating to the
23 certification of a physician required under
24 section 1814(a)(2)(C).”.

1 (b) REPORT.—Not later than one year after the date
 2 of the enactment of this Act, the Secretary of Health and
 3 Human Services shall submit to Congress a report con-
 4 taining the recommendations of the Secretary with respect
 5 to the feasibility and advisability of including home health
 6 services furnished by telecommunications systems as a
 7 home health service for purposes of—

8 (1) payment for such services under section
 9 1895 of the Social Security Act (42 U.S.C. 1395fff),
 10 and

11 (2) requirements with respect to physician cer-
 12 tification of the need for home health services under
 13 section 1814(a)(2)(C) of such Act (42 U.S.C.
 14 1395f(a)(2)(C)).

15 **Subtitle B—Direct Graduate** 16 **Medical Education**

17 **SEC. 311. NOT COUNTING CERTAIN GERIATRIC RESIDENTS** 18 **AGAINST GRADUATE MEDICAL EDUCATION** 19 **LIMITATIONS.**

20 For cost reporting periods beginning on or after Oc-
 21 tober 1, 2000, and before October 1, 2005, in applying
 22 the limitations regarding the total number of full-time
 23 equivalent interns and residents in the field of allopathic
 24 or osteopathic medicine under subsections (d)(5)(B)(v)
 25 and (h)(4)(F) of section 1886 of the Social Security Act

1 (42 U.S.C. 1395ww) for a hospital, the Secretary of
 2 Health and Human Services shall not take into account
 3 a maximum of 3 interns or residents in the field of geri-
 4 atric medicine to the extent the hospital increases the
 5 number of geriatric interns or residents above the number
 6 of such interns or residents for the hospital's most recent
 7 cost reporting period ending before October 1, 2000.

8 **SEC. 312. PROGRAM OF PAYMENTS TO CHILDREN'S HOS-**
 9 **PITALS THAT OPERATE GRADUATE MEDICAL**
 10 **EDUCATION PROGRAMS.**

11 Part A of title XI (42 U.S.C. 1301 et seq.) is amend-
 12 ed by adding after section 1150 the following new section:

13 "PROGRAM OF PAYMENTS TO CHILDREN'S HOSPITALS
 14 THAT OPERATE GRADUATE MEDICAL EDUCATION
 15 PROGRAMS

16 "SEC. 1150A. (a) PAYMENTS.—The Secretary shall
 17 make 2 payments under this section to each children's
 18 hospital for each of fiscal years 2002 through 2005, 1 for
 19 the direct expenses and the other for the indirect expenses
 20 associated with operating approved graduate medical resi-
 21 dency training programs.

22 "(b) AMOUNT OF PAYMENTS.—

23 "(1) IN GENERAL.—Subject to paragraph (2),
 24 the amounts payable under this section to a chil-
 25 dren's hospital for an approved graduate medical

1 residency training program for a fiscal year are each
2 of the following amounts:

3 “(A) DIRECT EXPENSE AMOUNT.—The
4 amount determined under subsection (c) for di-
5 rect expenses associated with operating ap-
6 proved graduate medical residency training pro-
7 grams.

8 “(B) INDIRECT EXPENSE AMOUNT.—The
9 amount determined under subsection (d) for in-
10 direct expenses associated with the treatment of
11 more severely ill patients and the additional
12 costs relating to teaching residents in such pro-
13 grams.

14 “(2) CAPPED AMOUNT.—

15 “(A) IN GENERAL.—The total of the pay-
16 ments made to children’s hospitals under sub-
17 paragraph (A) or (B) of paragraph (1) in a fis-
18 cal year shall not exceed the funds appropriated
19 under paragraph (1) or (2), respectively, of sub-
20 section (f) for such payments for that fiscal
21 year.

22 “(B) PRO RATA REDUCTIONS OF PAY-
23 MENTS FOR DIRECT EXPENSES.—If the Sec-
24 retary determines that the amount of funds ap-
25 propriated under subsection (f)(1) for a fiscal

1 year is insufficient to provide the total amount
2 of payments otherwise due for such periods
3 under paragraph (1)(A), the Secretary shall re-
4 duce the amounts so payable on a pro rata
5 basis to reflect such shortfall.

6 “(c) AMOUNT OF PAYMENT FOR DIRECT GRADUATE
7 MEDICAL EDUCATION.—

8 “(1) IN GENERAL.—The amount determined
9 under this subsection for payments to a children’s
10 hospital for direct graduate expenses relating to ap-
11 proved graduate medical residency training pro-
12 grams for a fiscal year is equal to the product of—

13 “(A) the updated per resident amount for
14 direct graduate medical education, as deter-
15 mined under paragraph (2); and

16 “(B) the average number of full-time
17 equivalent residents in the hospital’s graduate
18 approved medical residency training programs
19 (as determined under section 1886(h)(4)) dur-
20 ing the fiscal year.

21 “(2) UPDATED PER RESIDENT AMOUNT FOR DI-
22 RECT GRADUATE MEDICAL EDUCATION.—The up-
23 dated per resident amount for direct graduate med-
24 ical education for a hospital for a fiscal year is an
25 amount determined as follows:

1 “(A) DETERMINATION OF HOSPITAL SIN-
2 GLE PER RESIDENT AMOUNT.—The Secretary
3 shall compute for each hospital operating an
4 approved graduate medical education program
5 (regardless of whether or not it is a children’s
6 hospital) a single per resident amount equal to
7 the average (weighted by number of full-time
8 equivalent residents) of the primary care per
9 resident amount and the non-primary care per
10 resident amount computed under section
11 1886(h)(2) for cost reporting periods ending
12 during fiscal year 1997.

13 “(B) DETERMINATION OF WAGE AND NON-
14 WAGE-RELATED PROPORTION OF THE SINGLE
15 PER RESIDENT AMOUNT.—The Secretary shall
16 estimate the average proportion of the single
17 per resident amounts computed under subpara-
18 graph (A) that is attributable to wages and
19 wage-related costs.

20 “(C) STANDARDIZING PER RESIDENT
21 AMOUNTS.—The Secretary shall establish a
22 standardized per resident amount for each such
23 hospital—

24 “(i) by dividing the single per resident
25 amount computed under subparagraph (A)

1 into a wage-related portion and a non-
2 wage-related portion by applying the pro-
3 portion determined under subparagraph
4 (B);

5 “(ii) by dividing the wage-related por-
6 tion by the factor applied under section
7 1886(d)(3)(E) for discharges occurring
8 during fiscal year 1999 for the hospital’s
9 area; and

10 “(iii) by adding the non-wage-related
11 portion to the amount computed under
12 clause (ii).

13 “(D) DETERMINATION OF NATIONAL AV-
14 ERAGE.—The Secretary shall compute a na-
15 tional average per resident amount equal to the
16 average of the standardized per resident
17 amounts computed under subparagraph (C) for
18 such hospitals, with the amount for each hos-
19 pital weighted by the average number of full-
20 time equivalent residents at such hospital.

21 “(E) APPLICATION TO INDIVIDUAL HOS-
22 PITALS.—The Secretary shall compute for each
23 such hospital that is a children’s hospital a per
24 resident amount—

1 “(i) by dividing the national average
2 per resident amount computed under sub-
3 paragraph (D) into a wage-related portion
4 and a non-wage-related portion by applying
5 the proportion determined under subpara-
6 graph (B);

7 “(ii) by multiplying the wage-related
8 portion by the factor described in subpara-
9 graph (C)(ii) for the hospital’s area; and

10 “(iii) by adding the non-wage-related
11 portion to the amount computed under
12 clause (ii).

13 “(F) UPDATING RATE.—The Secretary
14 shall update such per resident amount for each
15 such children’s hospital by the estimated per-
16 centage increase in the Consumer Price Index
17 for all urban consumers (U.S. city average)
18 during the period beginning October 1997, and
19 ending with the midpoint of the Federal fiscal
20 year for which payments are made.

21 “(d) AMOUNT OF PAYMENT FOR INDIRECT MEDICAL
22 EDUCATION.—

23 “(1) IN GENERAL.—The amount determined
24 under this subsection for payments to a children’s
25 hospital for indirect expenses associated with the

1 treatment of more severely ill patients and the addi-
2 tional costs related to the teaching of residents for
3 a fiscal year is equal to an amount determined ap-
4 propriate by the Secretary.

5 “(2) FACTORS.—In determining the amount
6 under paragraph (1), the Secretary shall—

7 “(A) take into account variations in case
8 mix and regional wage levels among children’s
9 hospitals and the number of full-time equivalent
10 residents in the hospitals’ approved graduate
11 medical residency training programs; and

12 “(B) assure that the aggregate of the pay-
13 ments for indirect expenses associated with the
14 treatment of more severely ill patients and the
15 additional costs related to the teaching of resi-
16 dents under this section in a fiscal year are
17 equal to the amount appropriated for such ex-
18 penses for the fiscal year involved under sub-
19 section (f)(2).

20 “(e) MAKING OF PAYMENTS.—

21 “(1) INTERIM PAYMENTS.—The Secretary shall
22 determine, before the beginning of each fiscal year
23 involved for which payments may be made for a hos-
24 pital under this section, the amounts of the pay-
25 ments for direct graduate medical education and in-

1 direct medical education for such fiscal year and
2 shall (subject to paragraph (2)) make the payments
3 of such amounts in 26 equal interim installments
4 during such period. Such interim payments to each
5 individual hospital shall be based on the number of
6 residents reported in the hospital's most recently
7 filed medicare cost report prior to the application
8 date for the Federal fiscal year for which the interim
9 payment amounts are established.

10 “(2) WITHHOLDING.—

11 “(A) IN GENERAL.—Subject to subpara-
12 graph (B), the Secretary shall withhold 25 per-
13 cent from each interim installment for direct
14 and indirect graduate medical education paid
15 under paragraph (1).

16 “(B) REDUCTION OF WITHHOLDING.—The
17 Secretary shall reduce the percent withheld
18 from each installment pursuant to subpara-
19 graph (A) if the Secretary determines that such
20 reduced percent will provide the Secretary with
21 a reasonable level of assurance that most hos-
22 pitals will not be overpaid on an interim basis.

23 “(3) RECONCILIATION.—Prior to the end of
24 each fiscal year, the Secretary shall determine any
25 changes to the number of residents reported by a

1 hospital and shall use that number of residents to
2 determine the final amount payable to the hospital
3 for the current fiscal year for both direct expense
4 and indirect expense amounts. Based on such deter-
5 mination, the Secretary shall recoup any overpay-
6 ments made or pay any balance due to the extent
7 possible. In the event that a hospital's interim pay-
8 ments were greater than the final amount to which
9 it is entitled, the Secretary shall have the option of
10 recouping that excess amount in determining the
11 amount to be paid in the subsequent year to that
12 hospital. The final amount so determined shall be
13 considered a final intermediary determination for
14 purposes of applying section 1878 and shall be sub-
15 ject to review under that section in the same manner
16 as the amount of payment under section 1886(d) is
17 subject to review under such section.

18 “(f) AUTHORIZATION OF APPROPRIATIONS.—

19 “(1) DIRECT GRADUATE MEDICAL EDU-
20 CATION.—

21 “(A) IN GENERAL.—There are appro-
22 priated, out of any money in the Treasury not
23 otherwise appropriated, for payments under
24 subsection (b)(1)(A) for each of fiscal years
25 2002 through 2005, \$95,000,000.

1 “(B) CARRYOVER OF EXCESS.—The
2 amounts appropriated under subparagraph (A)
3 for each fiscal year shall remain available for
4 obligation through the end of the subsequent
5 fiscal year.

6 “(2) INDIRECT MEDICAL EDUCATION.—There
7 are appropriated, out of any money in the Treasury
8 not otherwise appropriated, for payments under sub-
9 section (b)(1)(A) for each of fiscal years 2002
10 through 2005, \$190,000,000.

11 “(g) DEFINITIONS.—In this section:

12 “(1) APPROVED GRADUATE MEDICAL RESI-
13 DENCY TRAINING PROGRAM.—The term ‘approved
14 graduate medical residency training program’ has
15 the meaning given the term ‘approved medical resi-
16 dency training program’ in section 1886(h)(5)(A).

17 “(2) CHILDREN’S HOSPITAL.—The term ‘chil-
18 dren’s hospital’ means a hospital with a medicare
19 payment agreement and which is excluded from the
20 medicare inpatient prospective payment system pur-
21 suant to section 1886(d)(1)(B)(iii) and its accom-
22 panying regulations.

23 “(3) DIRECT GRADUATE MEDICAL EDUCATION
24 COSTS.—The term ‘direct graduate medical edu-

1 cation costs’ has the meaning given such term in
 2 section 1886(h)(5)(C).”.

3 **SEC. 313. AUTHORITY TO INCLUDE COSTS OF TRAINING OF**
 4 **CLINICAL PSYCHOLOGISTS IN PAYMENTS TO**
 5 **HOSPITALS.**

6 Effective for cost reporting periods beginning on or
 7 after October 1, 1999, for purposes of payments to hos-
 8 pitals under the medicare program under title XVIII of
 9 the Social Security Act (42 U.S.C. 1395 et seq.) for costs
 10 of approved educational activities (as defined in section
 11 413.85 of title 42 of the Code of Federal Regulations),
 12 such approved educational activities shall include the clin-
 13 ical portion of professional educational training programs,
 14 recognized by the Secretary, for clinical psychologists.

15 **SEC. 314. TREATMENT OF CERTAIN NEWLY ESTABLISHED**
 16 **RESIDENCY PROGRAMS IN COMPUTING**
 17 **MEDICARE PAYMENTS FOR THE COSTS OF**
 18 **MEDICAL EDUCATION.**

19 (a) IN GENERAL.—Section 1886(h)(4)(H) (42
 20 U.S.C. 1395ww(h)(4)(H)) is amended by adding at the
 21 end the following new clause:

22 “(v) TREATMENT OF CERTAIN NEWLY
 23 ESTABLISHED PROGRAMS.—Any hospital
 24 that has received payments under this sub-
 25 section for a cost reporting period ending

1 before January 1, 1995, and that operates
2 an approved medical residency training
3 program established on or after August 5,
4 1997, shall be treated as meeting the re-
5 quirements for an adjustment under the
6 rules prescribed pursuant to clause (i) with
7 respect to such program if—

8 “(I) such program received ac-
9 creditation from the American Council
10 of Graduate Medical Education not
11 later than August 5, 1998;

12 “(II) such program was in oper-
13 ation (with 1 or more residents in
14 training) as of January 1, 2000;

15 “(III) such hospital is located in
16 an area that is contiguous to a rural
17 area and serves individuals from such
18 rural area; and

19 “(IV) such hospital serves a med-
20 ical service area with a population
21 that is less than 500,000.”.

22 (b) EFFECTIVE DATE.—The amendment made by
23 subsection (a) shall take effect as if included in the enact-
24 ment of section 4623 of BBA (111 Stat. 477).

1 **SEC. 315. EXCEPTION TO ESTABLISHING THE NUMBER OF**
2 **RESIDENTS FOR CERTAIN HOSPITALS.**

3 (a) AMENDMENT TO LIMITATION ON RESIDENTS FOR
4 INDIRECT GRADUATE MEDICAL EDUCATION.—Section
5 1886(d)(5)(B)(v) (42 U.S.C. 1395ww(d)(5)(B)(v)) is
6 amended—

7 (1) by adding the following after “December
8 31, 1996” and before the period: “(except in the
9 case where a community health center held the ac-
10 creditation for an approved medical residency train-
11 ing program of a hospital during fiscal year 1997
12 and the hospital incurred all or substantially all of
13 the costs of training those residents at the commu-
14 nity health center, the total number of full-time
15 equivalent interns and residents for the hospital with
16 respect to such training program in the fields of
17 allopathic and osteopathic medicine may not exceed
18 the number of such full-time equivalent interns and
19 residents that trained at such hospital and such
20 community health center during the hospital’s cost
21 reporting period ending on or before December 31,
22 1997)”.

23 (b) AMENDMENT TO LIMITATION ON RESIDENTS FOR
24 DIRECT GRADUATE MEDICAL EDUCATION.—Section
25 1886(h)(4)(F) (42 U.S.C. 1395ww(h)(4)(F)) is
26 amended—

1 (1) in clause (i), by striking “Such rules” and
2 inserting “Subject to clause (iii), such rules”; and

3 (2) by adding at the end the following new
4 clause:

5 “(iii) SPECIAL RULE.—In the case
6 where a community health center held the
7 accreditation for an approved medical resi-
8 dency training program of a hospital dur-
9 ing fiscal year 1997 and the hospital in-
10 curred all or substantially all of the costs
11 of training those residents at the commu-
12 nity health center, the total number of full-
13 time equivalent residents before application
14 of weighting factors for the hospital (as de-
15 termined under this paragraph) with re-
16 spect to such training program in the
17 fields of allopathic medicine and osteo-
18 pathic medicine may not exceed the num-
19 ber of such full-time equivalent residents
20 that trained at such hospital and such
21 community health center during the hos-
22 pital’s cost reporting period ending on or
23 before December 31, 1997.”.

24 (c) DEFINITION OF COMMUNITY HEALTH CENTER.—
25 For the purposes of this section, the term “community

1 health center” has the meaning given the term “health
 2 center” in section 330(a) of the Public Health Service Act
 3 (42 U.S.C. 254b(a)).

4 (d) EFFECTIVE DATE.—The amendments made by
 5 subsections (a) and (b) shall take effect as if included in
 6 the enactment of the Balanced Budget Act of 1997 (Pub-
 7 lic Law 105–33).

8 **Subtitle C—Miscellaneous**

9 **Provisions**

10 **SEC. 321. WAIVER OF 24-MONTH WAITING PERIOD FOR**

11 **MEDICARE COVERAGE OF INDIVIDUALS DIS-**

12 **ABLED WITH AMYOTROPHIC LATERAL SCLE-**

13 **ROSIS (ALS).**

14 (a) IN GENERAL.—Section 226 (42 U.S.C. 426) is
 15 amended—

16 (1) by redesignating subsection (h) as sub-
 17 section (j) and by moving such subsection to the end
 18 of the section; and

19 (2) by inserting after subsection (g) the fol-
 20 lowing new subsection:

21 “(h) For purposes of applying this section in the case
 22 of an individual medically determined to have amyotrophic
 23 lateral sclerosis (ALS), the following special rules apply:

1 “(1) Subsection (b) shall be applied as if there
2 were no requirement for any entitlement to benefits,
3 or status, for a period longer than 1 month.

4 “(2) The entitlement under such subsection
5 shall begin with the first month (rather than twenty-
6 fifth month) of entitlement or status.

7 “(3) Subsection (f) shall not be applied.”.

8 (b) CONFORMING AMENDMENT.—Section 1837 (42
9 U.S.C. 1395p) is amended by adding at the end the fol-
10 lowing new subsection:

11 “(j) In applying this section in the case of an indi-
12 vidual who is entitled to benefits under part A pursuant
13 to the operation of section 226(h), the following special
14 rules apply:

15 “(1) The initial enrollment period under sub-
16 section (d) shall begin on the first day of the first
17 month in which the individual satisfies the require-
18 ment of section 1836(1).

19 “(2) In applying subsection (g)(1), the initial
20 enrollment period shall begin on the first day of the
21 first month of entitlement to disability insurance
22 benefits referred to in such subsection.”.

23 (c) EFFECTIVE DATE.—The amendments made by
24 this section shall apply to benefits for months beginning
25 after the date of enactment of this Act.

**TITLE IV—RURAL PROVIDER
PROVISIONS
Subtitle A—Critical Access
Hospitals**

**SEC. 401. PAYMENTS TO CRITICAL ACCESS HOSPITALS FOR
CLINICAL DIAGNOSTIC LABORATORY TESTS.**

(a) PAYMENT ON COST BASIS WITHOUT BENE-
FICIARY COST-SHARING.—

(1) IN GENERAL.—Section 1833(a)(6) (42
U.S.C. 1395l(a)(6)) is amended by inserting “(in-
cluding clinical diagnostic laboratory services fur-
nished by a critical access hospital)” after “out-
patient critical access hospital services”.

(2) NO BENEFICIARY COST-SHARING.—

(A) IN GENERAL.—Section 1834(g) (42
U.S.C. 1395m(g)) is amended by inserting
“(except that in the case of clinical diagnostic
laboratory services furnished by a critical access
hospital the amount of payment shall be equal
to 100 percent of the reasonable costs of the
critical access hospital in providing such serv-
ices)” before the period at the end.

(B) BBRA AMENDMENT.—Section 1834(g)
(42 U.S.C. 1395m(g)), as amended by section

1 403(d) of BBRA (113 Stat. 1501A–371), is
2 amended—

3 (i) in paragraph (1), by inserting
4 “(except that in the case of clinical diag-
5 nostic laboratory services furnished by a
6 critical access hospital the amount of pay-
7 ment shall be equal to 100 percent of the
8 reasonable costs of the critical access hos-
9 pital in providing such services)” after
10 “such services”; and

11 (ii) in paragraph (2)(A), by inserting
12 “(except that in the case of clinical diag-
13 nostic laboratory services furnished by a
14 critical access hospital the amount of pay-
15 ment shall be equal to 100 percent of the
16 reasonable costs of the critical access hos-
17 pital in providing such services)” before
18 the period at the end.

19 (b) CONFORMING AMENDMENTS.—Paragraphs
20 (1)(D)(i) and (2)(D)(i) of section 1833(a) (42 U.S.C.
21 1395l(a)(1)(D)(i); 1395l(a)(2)(D)(i)) are each amended
22 by striking “or which are furnished on an outpatient basis
23 by a critical access hospital”.

1 (c) TECHNICAL AMENDMENT.—Section 403(d)(2) of
2 BBRA (113 Stat. 1501A–371) is amended by striking
3 “subsection (a)” and inserting “paragraph (1)”.

4 (d) EFFECTIVE DATES.—

5 (1) IN GENERAL.—Except as provided in para-
6 graph (2), the amendments made by this section
7 shall apply to services furnished on or after Novem-
8 ber 29, 1999.

9 (2) BBRA AND TECHNICAL AMENDMENTS.—
10 The amendments made by subsections (a)(2)(B) and
11 (c) shall take effect as if included in the enactment
12 of section 403(d) of BBRA (113 Stat. 1501A–371).

13 **SEC. 402. REVISION OF PAYMENT FOR PROFESSIONAL**
14 **SERVICES PROVIDED BY A CRITICAL ACCESS**
15 **HOSPITAL.**

16 (a) IN GENERAL.—Section 1834(g)(2)(B) (42 U.S.C.
17 1395m(g)(2)(B)), as amended by section 403(d) of BBRA
18 (113 Stat. 1501A–371), is amended by inserting “120
19 percent of” after “hospital services,”.

20 (b) EFFECTIVE DATE.—The amendment made by
21 subsection (a) shall take effect as if included in the enact-
22 ment of section 403(d) of BBRA (113 Stat. 1501A–371).

1 **SEC. 403. PERMITTING CRITICAL ACCESS HOSPITALS TO**
2 **OPERATE PPS EXEMPT DISTINCT PART PSY-**
3 **CHIATRIC AND REHABILITATION UNITS.**

4 (a) CRITERIA FOR DESIGNATION AS A CRITICAL AC-
5 CESS HOSPITAL.—Section 1820(c)(2)(B)(iii) (42 U.S.C.
6 1395i–4(c)(2)(B)(iii)) is amended by inserting “excluding
7 any psychiatric or rehabilitation unit of the facility which
8 is a distinct part of the facility,” before “provides not”.

9 (b) DEFINITION OF PPS EXEMPT DISTINCT PART
10 PSYCHIATRIC AND REHABILITATION UNITS.—Section
11 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) is amended
12 by inserting before the last sentence the following new sen-
13 tence: “In establishing such definition, the Secretary may
14 not exclude from such definition a psychiatric or rehabili-
15 tation unit of a critical access hospital which is a distinct
16 part of such hospital solely because such hospital is ex-
17 empt from the prospective payment system under this sec-
18 tion.”.

19 (c) EFFECTIVE DATE.—The amendments made by
20 this section shall take effect on the date of enactment of
21 this Act.

1 **Subtitle B—Medicare Dependent,**
 2 **Small Rural Hospital Program**

3 **SEC. 411. MAKING THE MEDICARE DEPENDENT, SMALL**
 4 **RURAL HOSPITAL PROGRAM PERMANENT.**

5 (a) PAYMENT METHODOLOGY.—Section
 6 1886(d)(5)(G) (42 U.S.C. 1395ww(d)(5)(G)) is
 7 amended—

8 (1) in clause (i), by striking “and before Octo-
 9 ber 1, 2006,”; and

10 (2) in clause (ii)(II), by striking “and before
 11 October 1, 2006,”.

12 (b) CONFORMING AMENDMENTS.—

13 (1) TARGET AMOUNT.—Section 1886(b)(3)(D)
 14 (42 U.S.C. 1395ww(b)(3)(D)) is amended—

15 (A) in the matter preceding clause (i), by
 16 striking “and before October 1, 2006,”; and

17 (B) in clause (iv), by striking “through fis-
 18 cal year 2005,” and inserting “or any subse-
 19 quent fiscal year,”.

20 (2) PERMITTING HOSPITALS TO DECLINE RE-
 21 CLASSIFICATION.—Section 13501(e)(2) of the Omni-
 22 bus Budget Reconciliation Act of 1993 (42 U.S.C.
 23 1395ww note), as amended by section 404(b)(2) of
 24 BBRA (113 Stat. 1501A–372), is amended by strik-
 25 ing “or fiscal year 2000 through fiscal year 2005”

1 and inserting “fiscal year 2000, or any subsequent
2 fiscal year,”.

3 **SEC. 412. OPTION TO BASE ELIGIBILITY FOR MEDICARE DE-**
4 **PENDENT, SMALL RURAL HOSPITAL PRO-**
5 **GRAM ON DISCHARGES DURING ANY OF THE**
6 **3 MOST RECENT AUDITED COST REPORTING**
7 **PERIODS.**

8 (a) IN GENERAL.—Section 1886(d)(5)(G)(iv)(IV)
9 (42 U.S.C. 1395ww(d)(5)(G)(iv)(IV)) is amended by in-
10 serting “, or any of the 3 most recent audited cost report-
11 ing periods,” after “1987”.

12 (b) EFFECTIVE DATE.—The amendment made by
13 this section shall apply with respect to cost reporting peri-
14 ods beginning on or after the date of enactment of this
15 Act.

16 **Subtitle C—Sole Community**
17 **Hospitals**

18 **SEC. 421. EXTENSION OF OPTION TO USE REBASED TARGET**
19 **AMOUNTS TO ALL SOLE COMMUNITY HOS-**
20 **PITALS.**

21 (a) IN GENERAL.—Section 1886(b)(3)(I)(i) (42
22 U.S.C. 1395ww(b)(3)(I)(i)) is amended—

23 (1) in the matter preceding subclause (I)—

24 (A) by striking “that for its cost reporting
25 period beginning during 1999 is paid on the

1 basis of the target amount applicable to the
2 hospital under subparagraph (C) and that
3 elects (in a form and manner determined by the
4 Secretary) this subparagraph to apply to the
5 hospital”; and

6 (B) by striking “substituted for such tar-
7 get amount” and inserting “substituted, if such
8 substitution results in a greater payment under
9 this section for such hospital, for the amount
10 otherwise determined under subsection
11 (d)(5)(D)(i)”;

12 (2) in subclause (I), by striking “target amount
13 otherwise applicable” and all that follows through
14 “target amount’”)” and inserting “the amount other-
15 wise applicable to the hospital under subsection
16 (d)(5)(D)(i) (referred to in this clause as the ‘sub-
17 section (d)(5)(D)(i) amount’)”;

18 (3) in each of subclauses (II) and (III), by
19 striking “subparagraph (C) target amount” and in-
20 serting “subsection (d)(5)(D)(i) amount”.

21 (b) EFFECTIVE DATE.—The amendments made by
22 this section shall take effect as if included in the enact-
23 ment of section 405 of BBRA (113 Stat. 1501A–372).

1 **SEC. 422. DEEMING A CERTAIN HOSPITAL AS A SOLE COM-**
 2 **MUNITY HOSPITAL.**

3 Notwithstanding any other provision of law, for pur-
 4 poses of discharges occurring on or after October 1, 2000,
 5 the Greensville Memorial Hospital located in Emporia,
 6 Virginia shall be deemed to have satisfied the travel and
 7 time criteria under section 1886(d)(5)(D)(iii)(II) of the
 8 Social Security Act (42 U.S.C. 1395ww(d)(5)(D)(iii)(II))
 9 for classification as a sole community hospital.

10 **Subtitle D—Other Rural Hospital**
 11 **Provisions**

12 **SEC. 431. EXEMPTION OF HOSPITAL SWING-BED PROGRAM**
 13 **FROM THE PPS FOR SKILLED NURSING FA-**
 14 **CILITIES.**

15 (a) EXEMPTION FOR MEDICARE SWING-BED HOS-
 16 PITALS.—

17 (1) IN GENERAL.—Section 1888(e)(7) (42
 18 U.S.C. 1395yy(e)(7)(A)) is amended—

19 (A) in the heading, by striking “TRANSI-
 20 TION” and inserting “EXEMPTION”;

21 (B) by striking subparagraph (A) and in-
 22 serting the following new subparagraph:

23 “(A) IN GENERAL.—The prospective pay-
 24 ment system under this subsection shall not
 25 apply to items and services provided by a facil-
 26 ity described in subparagraph (B).”; and

1 (C) in subparagraph (B), by striking “, for
 2 which payment” and all that follows before the
 3 period.

4 (2) EFFECTIVE DATE.—The amendments made
 5 by paragraph (1) shall take effect as if included in
 6 the enactment of section 4432 of BBA (111 Stat.
 7 414).

8 (b) CHANGE IN EFFECTIVE DATE OF BBRA AMEND-
 9 MENTS.—

10 (1) IN GENERAL.—Section 408(c) of BBRA
 11 (113 Stat. 1501A–375) is amended by striking “the
 12 date that is” and all that follows and inserting
 13 “January 1, 2001.”.

14 (2) EFFECTIVE DATE.—The amendment made
 15 by paragraph (1) shall take effect as if included in
 16 the enactment of section 408 of BBRA (113 Stat.
 17 1501A–375).

18 **SEC. 432. PERMANENT GUARANTEE OF PRE-BBA PAYMENT**
 19 **LEVELS FOR OUTPATIENT SERVICES FUR-**
 20 **NISHED BY RURAL HOSPITALS.**

21 (a) IN GENERAL.—Section 1833(t)(7)(D), as amend-
 22 ed by section 203, is amended to read as follows:

23 “(D) HOLD HARMLESS PROVISIONS FOR
 24 SMALL RURAL AND CANCER HOSPITALS.—In
 25 the case of a hospital located in a rural area

and that has not more than 100 beds or a hospital described in section 1886(d)(1)(B)(v), for covered OPD services for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the enactment of section 202 of BBRA (111 Stat. 1501A–342).

SEC. 433. TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES.

(a) IN GENERAL.—Section 1848(i) (42 U.S.C. 1395w–4(i)) is amended by adding at the end the following new paragraph:

“(4) TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES.—

“(A) IN GENERAL.—Notwithstanding any other provision of law, when an independent laboratory furnishes the technical component of a physician pathology service with respect to a fee-for-service medicare beneficiary who is a patient of a grandfathered hospital, such component shall be treated as a service for which pay-

1 ment shall be made to the laboratory under this
2 section and not as—

3 “(i) an inpatient hospital service for
4 which payment is made to the hospital
5 under section 1886(d); or

6 “(ii) a hospital outpatient service for
7 which payment is made to the hospital
8 under the prospective payment system
9 under section 1834(t).

10 “(B) DEFINITIONS.—In this paragraph:

11 “(i) GRANDFATHERED HOSPITAL.—
12 The term ‘grandfathered hospital’ means a
13 hospital that had an arrangement with an
14 independent laboratory—

15 “(I) that was in effect as of July
16 22, 1999; and

17 “(II) under which the laboratory
18 furnished the technical component of
19 physician pathology services with re-
20 spect to patients of the hospital and
21 submitted a claim for payment for
22 such component to a carrier with a
23 contract under section 1842 (and not
24 to the hospital).

1 “(ii) FEE-FOR-SERVICE MEDICARE
2 BENEFICIARY.—The term ‘fee-for-service
3 medicare beneficiary’ means an individual
4 who is not enrolled—

5 “(I) in a Medicare+Choice plan
6 under part C;

7 “(II) in a plan offered by an eli-
8 gible organization under section 1876;

9 “(III) with a PACE provider
10 under section 1894;

11 “(IV) in a medicare managed
12 care demonstration project; or

13 “(V) in the case of a service fur-
14 nished to an individual on an out-
15 patient basis, in a health care prepay-
16 ment plan under section
17 1833(a)(1)(A).”.

18 (b) EFFECTIVE DATE.—The amendment made by
19 this section shall apply to services furnished on or after
20 January 1, 2001.

1 **Subtitle E—Other Rural Provisions**

2 **SEC. 441. REVISION OF BONUS PAYMENTS FOR SERVICES** 3 **FURNISHED IN HEALTH PROFESSIONAL** 4 **SHORTAGE AREAS.**

5 (a) EXPANSION OF BONUS PAYMENTS TO INCLUDE
6 PHYSICIAN ASSISTANT AND NURSE PRACTITIONER SERV-
7 ICES.—Section 1833(m) (42 U.S.C. 1395l(m)) is
8 amended—

9 (1) by inserting “(or services furnished by a
10 physician assistant or nurse practitioner that would
11 be physicians’ services if furnished by a physician)”
12 after “physicians’ services”;

13 (2) by inserting “, physician assistant (in the
14 case of a physician assistant described in subpara-
15 graph (C)(ii) of section 1842(b)(6)), or nurse practi-
16 tioner” after “physician”; and

17 (3) by striking “clause (A) of section
18 1842(b)(6)” and inserting “subparagraphs (A) and
19 (C)(i) of such section”.

20 (b) ELIMINATION OF REQUIREMENT TO MAKE
21 BONUS PAYMENTS ON MONTHLY OR QUARTERLY
22 BASIS.—Section 1833(m) (42 U.S.C. 1395l(m)) is amend-
23 ed by striking “(on a monthly or quarterly basis)”.

24 (c) EFFECTIVE DATES.—

1 (1) IN GENERAL.—The amendments made by
2 subsection (a) shall apply to services furnished on or
3 after July 1, 2001.

4 (2) MONTHLY OR QUARTERLY PAYMENTS.—The
5 amendment made by subsection (b) shall apply to
6 services furnished on or after the first day of the
7 first calendar quarter beginning at least 240 days
8 after the date of enactment of this Act.

9 **SEC. 442. PROVIDER-BASED RURAL HEALTH CLINIC CAP**
10 **EXEMPTION.**

11 (a) IN GENERAL.—The matter in section 1833(f) (42
12 U.S.C. 1395l(f)) preceding paragraph (1) is amended by
13 striking “with less than 50 beds” and inserting “with an
14 average daily patient census that does not exceed 50”.

15 (b) EFFECTIVE DATE.—The amendment made by
16 subparagraph (A) shall apply to services furnished on or
17 after January 1, 2001.

18 **SEC. 443. PAYMENT FOR CERTAIN PHYSICIAN ASSISTANT**
19 **SERVICES.**

20 (a) PAYMENT FOR CERTAIN PHYSICIAN ASSISTANT
21 SERVICES.—Section 1842(b)(6)(C) (42 U.S.C.
22 1395u(b)(6)(C)) is amended by striking “for such services
23 provided before January 1, 2003,”.

1 (b) EFFECTIVE DATE.—The amendment made by
 2 subsection (a) shall take effect on the date of enactment
 3 of this Act.

4 **SEC. 444. EXCLUSION OF CLINICAL SOCIAL WORKER SERV-**
 5 **ICES AND SERVICES PERFORMED UNDER A**
 6 **CONTRACT WITH A RURAL HEALTH CLINIC**
 7 **OR FEDERALLY QUALIFIED HEALTH CENTER**
 8 **FROM THE PPS FOR SNFs.**

9 (a) IN GENERAL.—Section 1888(e)(2)(A)(ii) (42
 10 U.S.C. 1395yy(e)(2)(A)(ii)) is amended—

11 (1) in the first sentence, by inserting “clinical
 12 social worker services,” after “qualified psychologist
 13 services,”; and

14 (2) by inserting after the first sentence the fol-
 15 lowing: “Services described in this clause also in-
 16 clude services that are provided by a physician, a
 17 physician assistant, a nurse practitioner, a certified
 18 nurse midwife, a qualified psychologist, or a clinical
 19 social worker who is employed, or otherwise under
 20 contract, with a rural health clinic or a Federally
 21 qualified health center.”.

22 (b) EFFECTIVE DATE.—The amendments made by
 23 this section shall apply to services provided on or after
 24 the date which is 60 days after the date of enactment of
 25 this Act.

1 **SEC. 445. COVERAGE OF MARRIAGE AND FAMILY THERA-**
 2 **PIST SERVICES PROVIDED IN RURAL HEALTH**
 3 **CLINICS.**

4 (a) COVERAGE OF MARRIAGE AND FAMILY THERA-
 5 PIST SERVICES.—

6 (1) PROVISION OF SERVICES IN RURAL HEALTH
 7 CLINICS.—Section 1861(aa)(1)(B) (42 U.S.C.
 8 1395x(aa)(1)(B)) is amended by striking “Sec-
 9 retary)” and inserting “Secretary), by a marriage
 10 and family therapist (as defined in subsection
 11 (xx)(2)),”.

12 (2) MARRIAGE AND FAMILY THERAPIST SERV-
 13 ICES DEFINED.—Section 1861 (42 U.S.C. 1395x),
 14 as amended by section 232, 233(a), 234(b), and
 15 250(b), is further amended by adding at the end the
 16 following new subsection:

17 “Marriage and Family Therapist Services
 18 “(yy)(1) The term ‘marriage and family therapist
 19 services’ means services performed by a marriage and
 20 family therapist (as defined in paragraph (2)) for the diag-
 21 nosis and treatment of mental illnesses, which the mar-
 22 riage and family therapist is legally authorized to perform
 23 under State law (or the State regulatory mechanism pro-
 24 vided by State law) of the State in which such services
 25 are performed, as would otherwise be covered if furnished
 26 by a physician or as an incident to a physician’s profes-

1 sional service, but only if no facility or other provider
2 charges or is paid any amounts with respect to the fur-
3 nishing of such services.

4 “(2) The term ‘marriage and family therapist’ means
5 an individual who—

6 “(A) possesses a master’s or doctoral degree
7 which qualifies for licensure or certification as a
8 marriage and family therapist pursuant to State
9 law;

10 “(B) after obtaining such degree has performed
11 at least 2 years of clinical supervised experience in
12 marriage and family therapy; and

13 “(C)(i) is licensed or certified as a marriage
14 and family therapist in the State in which marriage
15 and family therapist services are performed; or

16 “(ii) in the case of a State that does not pro-
17 vide for such licensure or certification, meets such
18 other criteria as the Secretary establishes.”.

19 (b) EFFECTIVE DATE.—The amendments made by
20 this section shall apply with respect to services furnished
21 on or after January 1, 2002.

1 **SEC. 446. CAPITAL INFRASTRUCTURE REVOLVING LOAN**
2 **PROGRAM.**

3 (a) IN GENERAL.—Part A of title XVI of the Public
4 Health Service Act (42 U.S.C. 300q et seq.) is amended
5 by adding at the end the following new section:

6 “CAPITAL INFRASTRUCTURE REVOLVING LOAN PROGRAM

7 “SEC. 1603. (a) AUTHORITY TO MAKE AND GUAR-
8 ANTEE LOANS.—

9 “(1) AUTHORITY TO MAKE LOANS.—The Sec-
10 retary may make loans from the fund established
11 under section 1602(d) to any rural entity for
12 projects for capital improvements, including—

13 “(A) the acquisition of land necessary for
14 the capital improvements;

15 “(B) the renovation or modernization of
16 any building;

17 “(C) the acquisition or repair of fixed or
18 major movable equipment; and

19 “(D) such other project expenses as the
20 Secretary determines appropriate.

21 “(2) AUTHORITY TO GUARANTEE LOANS.—

22 “(A) IN GENERAL.—The Secretary may
23 guarantee the payment of principal and interest
24 for loans to rural entities for projects for cap-
25 ital improvements described in paragraph (1) to
26 non-Federal lenders.

1 “(B) INTEREST SUBSIDIES.—In the case
2 of a guarantee of any loan to a rural entity
3 under subparagraph (A)(i), the Secretary may
4 pay to the holder of such loan and for and on
5 behalf of the project for which the loan was
6 made, amounts sufficient to reduce by not more
7 than 3 percentage points of the net effective in-
8 terest rate otherwise payable on such loan.

9 “(b) AMOUNT OF LOAN.—The principal amount of
10 a loan directly made or guaranteed under subsection (a)
11 for a project for capital improvement may not exceed
12 \$5,000,000.

13 “(c) FUNDING LIMITATIONS.—

14 “(1) GOVERNMENT CREDIT SUBSIDY EXPO-
15 SURE.—The total of the Government credit subsidy
16 exposure under the Credit Reform Act of 1990 scor-
17 ing protocol with respect to the loans outstanding at
18 any time with respect to which guarantees have been
19 issued, or which have been directly made, under sub-
20 section (a) may not exceed \$50,000,000 per year.

21 “(2) TOTAL AMOUNTS.—Subject to paragraph
22 (1), the total of the principal amount of all loans di-
23 rectly made or guaranteed under subsection (a) may
24 not exceed \$250,000,000 per year.

25 “(d) ADDITIONAL ASSISTANCE.—

1 “(1) NONREPAYABLE GRANTS.—Subject to
2 paragraph (2), the Secretary may make a grant to
3 a rural entity, in an amount not to exceed \$50,000,
4 for purposes of capital assessment and business
5 planning.

6 “(2) LIMITATION.—The cumulative total of
7 grants awarded under this subsection may not ex-
8 ceed \$2,500,000 per year.

9 “(e) TERMINATION OF AUTHORITY.—The Secretary
10 may not directly make or guarantee any loan under sub-
11 section (a) or make a grant under subsection (d) after
12 September 30, 2005.”.

13 (b) RURAL ENTITY DEFINED.—Section 1624 of the
14 Public Health Service Act (42 U.S.C. 300s–3) is amended
15 by adding at the end the following new paragraph:

16 “(15)(A) The term ‘rural entity’ includes—

17 “(i) a rural health clinic, as defined in sec-
18 tion 1861(aa)(2) of the Social Security Act;

19 “(ii) any medical facility with at least 1,
20 but less than 50, beds that is located in—

21 “(I) a county that is not part of a
22 metropolitan statistical area; or

23 “(II) a rural census tract of a metro-
24 politan statistical area (as determined
25 under the most recent modification of the

1 Goldsmith Modification, originally pub-
 2 lished in the Federal Register on February
 3 27, 1992 (57 Fed. Reg. 6725));

4 “(iii) a hospital that is classified as a
 5 rural, regional, or national referral center under
 6 section 1886(d)(5)(C) of the Social Security
 7 Act; and

8 “(iv) a hospital that is a sole community
 9 hospital (as defined in section
 10 1886(d)(5)(D)(iii) of the Social Security Act).

11 “(B) For purposes of subparagraph (A), the
 12 fact that a clinic, facility, or hospital has been geo-
 13 graphically reclassified under the medicare program
 14 under title XVIII of the Social Security Act shall not
 15 preclude a hospital from being considered a rural en-
 16 tity under clause (i) or (ii) of subparagraph (A).”.

17 (c) CONFORMING AMENDMENTS.—Section 1602 of
 18 the Public Health Service Act (42 U.S.C. 300q–2) is
 19 amended—

20 (1) in subsection (b)(2)(D), by inserting “or
 21 1603(a)(2)(B)” after “1601(a)(2)(B)”; and

22 (2) in subsection (d)—

23 (A) in paragraph (1)(C), by striking “sec-
 24 tion 1601(a)(2)(B)” and inserting “sections
 25 1601(a)(2)(B) and 1603(a)(2)(B)”; and

1 (B) in paragraph (2)(A), by inserting “or
 2 1603(a)(2)(B)” after “1601(a)(2)(B)”.

3 **SEC. 447. GRANTS FOR UPGRADING DATA SYSTEMS.**

4 (a) IN GENERAL.—Part B of title XVI of the Public
 5 Health Service Act (42 U.S.C. 300r et seq.) is amended
 6 by adding at the end the following new section:

7 “GRANTS FOR UPGRADING DATA SYSTEMS

8 “SEC. 1611. (a) GRANTS TO HOSPITALS.—

9 “(1) IN GENERAL.—The Secretary shall estab-
 10 lish a program to make grants to hospitals that have
 11 submitted applications in accordance with subsection
 12 (c) to assist eligible small rural hospitals in offset-
 13 ting the costs of establishing data systems—

14 “(A) required to—

15 “(i) implement prospective payment
 16 systems under title XVIII of the Social Se-
 17 curity Act; and

18 “(ii) comply with the administrative
 19 simplification requirements under part C
 20 of title XI of such Act; or

21 “(B) to reduce medication errors.

22 “(2) COSTS.—For purposes of paragraph (1),
 23 the term ‘costs’ shall include costs associated with—

24 “(A) purchasing computer software and
 25 hardware; and

1 “(B) providing education and training to
2 hospital staff on computer information systems.

3 “(3) LIMITATION.—A hospital that has received
4 a grant under section 142 of the Medicare, Med-
5 icaid, and SCHIP Balanced Budget Refinement Act
6 of 2000 is not eligible to receive a grant under this
7 section.

8 “(b) ELIGIBLE SMALL RURAL HOSPITAL DE-
9 FINED.—For purposes of this section, the term ‘eligible
10 small rural hospital’ means a non-Federal, short-term gen-
11 eral acute care hospital that—

12 “(1) is located in a rural area, as defined for
13 purposes of section 1886(d) of the Social Security
14 Act; and

15 “(2) has less than 50 beds.

16 “(c) APPLICATION.—A hospital seeking a grant
17 under this section shall submit an application to the Sec-
18 retary at such time and in such form and manner as the
19 Secretary specifies.

20 “(d) AMOUNT OF GRANT.—A grant to a hospital
21 under this section may not exceed \$100,000.

22 “(e) REPORTS.—

23 “(1) INFORMATION.—A hospital receiving a
24 grant under this section shall furnish the Secretary

1 with such information as the Secretary may require
2 to—

3 “(A) evaluate the project for which the
4 grant is made; and

5 “(B) ensure that the grant is expended for
6 the purposes for which it is made.

7 “(2) TIMING OF SUBMISSION.—

8 “(A) INTERIM REPORTS.—The Secretary
9 shall report to the Committee on Commerce of
10 the House of Representatives and the Com-
11 mittee on Health, Education, Labor, and Pen-
12 sions of the Senate at least annually on the
13 grant program established under this section,
14 including in such report information on the
15 number of grants made, the nature of the
16 projects involved, the geographic distribution of
17 grant recipients, and such other matters as the
18 Secretary deems appropriate.

19 “(B) FINAL REPORT.—The Secretary shall
20 submit a final report to such committees not
21 later than 180 days after the completion of all
22 of the projects for which a grant is made under
23 this section.

1 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
 2 are authorized to be appropriated such sums as may be
 3 necessary for grants under this section.”.

4 (b) CONFORMING AMENDMENT.—Section 1820(g)(3)
 5 (42 U.S.C. 1395i–4(g)(3)) is repealed.

6 **SEC. 448. RELIEF FOR FINANCIALLY DISTRESSED RURAL**
 7 **HOSPITALS.**

8 Title III of the Public Health Service Act (42 U.S.C.
 9 241 et seq.) is amended by inserting after section 330D
 10 the following new section:

11 **“SEC. 330E. RELIEF FOR FINANCIALLY DISTRESSED RURAL**
 12 **HOSPITALS.**

13 “(a) GRANTS TO SMALL RURAL HOSPITALS.—The
 14 Secretary, acting through the Health Resources and Serv-
 15 ices Administration, may award grants to eligible small
 16 rural hospitals that have submitted applications in accord-
 17 ance with subsection (c) to provide relief for financial dis-
 18 tress that has a negative impact on access to care for
 19 beneficiaries under the medicare program under title
 20 XVIII of the Social Security Act (42 U.S.C. 1395 et seq.)
 21 that reside in a rural area.

22 “(b) ELIGIBLE SMALL RURAL HOSPITAL DE-
 23 FINED.—For purposes of this paragraph, the term ‘eligi-
 24 ble small rural hospital’ means a non-Federal, short-term
 25 general acute care hospital that—

1 “(1) is located in a rural area (as defined for
2 purposes of section 1886(d) of the Social Security
3 Act (42 U.S.C. 1395ww(d))); and

4 “(2) has less than 50 beds.

5 “(c) APPLICATION AND APPROVAL.—

6 “(1) APPLICATION.—Each eligible small rural
7 hospital that desires to receive a grant under this
8 paragraph shall submit an application to the Sec-
9 retary, at such time, in such form and manner, and
10 accompanied by such additional information as the
11 Secretary may reasonably require.

12 “(2) APPROVAL.—The Secretary shall approve
13 applications submitted under paragraph (1) based
14 on a methodology developed by the Secretary in con-
15 sultation with the Office of Rural Health Policy.

16 “(d) AMOUNT OF GRANT.—A grant to an eligible
17 small rural hospital under this paragraph may not exceed
18 \$250,000.

19 “(e) USE OF FUNDS.—

20 “(1) IN GENERAL.—Except as provided in para-
21 graph (2), an eligible small rural hospital may use
22 amounts received under a grant under this section to
23 temporarily offset financial operating losses, with
24 emphasis on those losses attributable to reimburse-
25 ment formula changes that resulted from the Bal-

1 anced Budget Act of 1997, in order to ensure con-
2 tinued operation and short-term sustainability or to
3 address emergency physical capital needs that might
4 otherwise result in closure.

5 “(2) PROHIBITED USES.—A hospital may not
6 use funds received under a grant under this section
7 for new construction, the purchase of medical equip-
8 ment, or for computer software or hardware.

9 “(f) REPORT.—

10 “(1) INFORMATION.—A hospital receiving a
11 grant under this section shall furnish the Secretary
12 with such information as the Secretary may require
13 to evaluate the project for which the grant is made
14 and to ensure that the grant is expended for the
15 purposes for which it is made.

16 “(2) REPORTING.—

17 “(A) ANNUAL REPORTS.—

18 “(i) IN GENERAL.—Not later than
19 December 31 of each year (beginning with
20 2001), the Secretary shall submit a report
21 to the committees of jurisdiction of the
22 House of Representatives and the Senate
23 on the grant program established under
24 this section.

1 “(ii) INFORMATION INCLUDED.—The
 2 report submitted under clause (i) shall in-
 3 clude information on the number of grants
 4 made, the nature of the projects involved,
 5 the geographic distribution of grant recipi-
 6 ents, and such other information as the
 7 Secretary determines is appropriate.

8 “(B) FINAL REPORT.—Not later than 180
 9 days after the completion of all of the projects
 10 for which a grant is made under this section,
 11 the Secretary shall submit a final report on the
 12 grant program established under this section to
 13 the committees described in subparagraph (A).

14 “(g) APPROPRIATIONS.—There are appropriated, out
 15 of any money in the Treasury not otherwise appropriated,
 16 for making grants under this section \$25,000,000 for each
 17 of the fiscal years 2001 through 2005.”.

18 **SEC. 449. REFINEMENT OF MEDICARE REIMBURSEMENT**
 19 **FOR TELEHEALTH SERVICES.**

20 (a) REVISION OF TELEHEALTH PAYMENT METHOD-
 21 ODOLOGY AND ELIMINATION OF FEE-SHARING REQUIRE-
 22 MENT.—Section 4206(b) of the Balanced Budget Act of
 23 1997 (42 U.S.C. 1395l note) is amended to read as fol-
 24 lows:

1 “(b) METHODOLOGY FOR DETERMINING AMOUNT OF
2 PAYMENTS.—

3 “(1) IN GENERAL.—The Secretary shall pay
4 to—

5 “(A) the physician or practitioner at a dis-
6 tant site that provides an item or service under
7 subsection (a) an amount equal to the amount
8 that such physician or provider would have been
9 paid had the item or service been provided with-
10 out the use of a telecommunications system;
11 and

12 “(B) the originating site a facility fee for
13 facility services furnished in connection with
14 such item or service.

15 “(2) APPLICATION OF PART B COINSURANCE
16 AND DEDUCTIBLE.—Any payment made under this
17 section shall be subject to the coinsurance and de-
18 ductible requirements under subsections (a)(1) and
19 (b) of section 1833 of the Social Security Act (42
20 U.S.C. 1395l).

21 “(3) DEFINITIONS.—In this subsection:

22 “(A) DISTANT SITE.—The term ‘distant
23 site’ means the site at which the physician or
24 practitioner is located at the time the item or

1 service is provided via a telecommunications
2 system.

3 “(B) FACILITY FEE.—The term ‘facility
4 fee’ means an amount equal to—

5 “(i) for 2000 and 2001, \$20; and

6 “(ii) for a subsequent year, the facil-
7 ity fee under this subsection for the pre-
8 vious year increased by the percentage in-
9 crease in the MEI (as defined in section
10 1842(i)(3)) for such subsequent year.

11 “(C) ORIGINATING SITE.—

12 “(i) IN GENERAL.—The term ‘origi-
13 nating site’ means the site described in
14 clause (ii) at which the eligible telehealth
15 beneficiary under the medicare program is
16 located at the time the item or service is
17 provided via a telecommunications system.

18 “(ii) SITES DESCRIBED.—The sites
19 described in this paragraph are as follows:

20 “(I) On or before January 1,
21 2002, the office of a physician or a
22 practitioner, a critical access hospital,
23 a rural health clinic, and a Federally
24 qualified health center.

1 “(II) On or before January 1,
2 2003, a hospital, a skilled nursing fa-
3 cility, a comprehensive outpatient re-
4 habilitation facility, a renal dialysis
5 facility, an ambulatory surgical center,
6 an Indian Health Service facility, and
7 a community mental health center.”.

8 (b) ELIMINATION OF REQUIREMENT FOR TELEPRE-
9 SENDER.—Section 4206 of the Balanced Budget Act of
10 1997 (42 U.S.C. 1395l note) is amended—

11 (1) in subsection (a), by striking “, notwith-
12 standing that the individual physician” and all that
13 follows before the period at the end; and

14 (2) by adding at the end the following new sub-
15 section:

16 “(e) TELEPRESENTER NOT REQUIRED.—Nothing in
17 this section shall be construed as requiring an eligible tele-
18 health beneficiary to be presented by a physician or practi-
19 tioner for the provision of an item or service via a tele-
20 communications system.”.

21 (c) REIMBURSEMENT FOR MEDICARE BENE-
22 FICIARIES WHO DO NOT RESIDE IN A HPSA.—Section
23 4206(a) of the Balanced Budget Act of 1997 (42 U.S.C.
24 1395l note), as amended by subsection (b), is amended—

1 (1) by striking “IN GENERAL.—Not later than”
2 and inserting the following: “TELEHEALTH SERV-
3 ICES REIMBURSED.—

4 “(1) IN GENERAL.—Not later than”;

5 (2) by striking “furnishing a service for which
6 payment” and all that follows before the period and
7 inserting “to an eligible telehealth beneficiary”; and

8 (3) by adding at the end the following new
9 paragraph:

10 “(2) ELIGIBLE TELEHEALTH BENEFICIARY DE-
11 FINED.—In this section, the term ‘eligible telehealth
12 beneficiary’ means a beneficiary under the medicare
13 program under title XVIII of the Social Security Act
14 (42 U.S.C. 1395 et seq.) that resides in—

15 “(A) an area that is designated as a health
16 professional shortage area under section
17 332(a)(1)(A) of the Public Health Service Act
18 (42 U.S.C. 254e(a)(1)(A));

19 “(B) a county that is not included in a
20 Metropolitan Statistical Area; or

21 “(C) an inner-city area that is medically
22 underserved (as defined in section 330(b)(3) of
23 the Public Health Service Act (42 U.S.C.
24 254b(b)(3))).”.

1 (d) TELEHEALTH COVERAGE FOR DIRECT PATIENT
2 CARE.—

3 (1) IN GENERAL.—Section 4206 of the Bal-
4 anced Budget Act of 1997 (42 U.S.C. 1395l note),
5 as amended by subsection (c), is amended—

6 (A) in subsection (a)(1), by striking “pro-
7 fessional consultation via telecommunications
8 systems with a physician” and inserting “items
9 and services for which payment may be made
10 under such part that are furnished via a tele-
11 communications system by a physician”; and

12 (B) by adding at the end the following new
13 subsection:

14 “(f) COVERAGE OF ITEMS AND SERVICES.—Payment
15 for items and services provided pursuant to subsection (a)
16 shall include payment for professional consultations, office
17 visits, office psychiatry services, including any service
18 identified as of July 1, 2000, by HCPCS codes 99241–
19 99275, 99201–99215, 90804–90815, and 90862.”.

20 (2) STUDY AND REPORT REGARDING ADDI-
21 TIONAL ITEMS AND SERVICES.—

22 (A) STUDY.—The Secretary of Health and
23 Human Services shall conduct a study to iden-
24 tify items and services in addition to those de-
25 scribed in section 4206(f) of the Balanced

1 Budget Act of 1997 (as added by paragraph
2 (1)) that would be appropriate to provide pay-
3 ment under title XVIII of the Social Security
4 Act (42 U.S.C. 1395 et seq.).

5 (B) REPORT.—Not later than 2 years after
6 the date of enactment of this Act, the Secretary
7 shall submit a report to Congress on the study
8 conducted under subparagraph (A) together
9 with such recommendations for legislation that
10 the Secretary determines are appropriate.

11 (e) ALL PHYSICIANS AND PRACTITIONERS ELIGIBLE
12 FOR TELEHEALTH REIMBURSEMENT.—Section 4206(a)
13 of the Balanced Budget Act of 1997 (42 U.S.C. 1395l
14 note), as amended by subsection (d), is amended—

15 (1) in paragraph (1), by striking “(described in
16 section 1842(b)(18)(C) of such Act (42 U.S.C.
17 1395u(b)(18)(C))”; and

18 (2) by adding at the end the following new
19 paragraph:

20 “(3) PRACTITIONER DEFINED.—For purposes
21 of paragraph (1), the term ‘practitioner’ includes—

22 “(A) a practitioner described in section
23 1842(b)(18)(C) of the Social Security Act (42
24 U.S.C. 1395u(b)(18)(C)); and

1 “(B) a physical, occupational, or speech
2 therapist.”.

3 (f) TELEHEALTH SERVICES PROVIDED USING
4 STORE-AND-FORWARD TECHNOLOGIES.—Section
5 4206(a)(1) of the Balanced Budget Act of 1997 (42
6 U.S.C. 1395l note), as amended by subsection (e), is
7 amended by adding at the end the following new para-
8 graph:

9 “(4) USE OF STORE-AND-FORWARD TECH-
10 NOLOGIES.—For purposes of paragraph (1), in the
11 case of any Federal telemedicine demonstration pro-
12 gram in Alaska or Hawaii, the term ‘telecommuni-
13 cations system’ includes store-and-forward tech-
14 nologies that provide for the asynchronous trans-
15 mission of health care information in single or multi-
16 media formats.”.

17 (g) FIVE-YEAR APPLICATION.—The amendments
18 made by this section shall apply to items and services pro-
19 vided on or after April 1, 2001, and before April 1, 2006.

20 **SEC. 450. MEDPAC STUDY ON LOW-VOLUME, ISOLATED**
21 **RURAL HEALTH CARE PROVIDERS.**

22 (a) STUDY.—The Medicare Payment Advisory Com-
23 mission established under section 1805 of the Social Secu-
24 rity Act (42 U.S.C. 1395b–6) (in this section referred to
25 as “MedPAC”) shall conduct a study on the effect of low

1 patient and procedure volume on the financial status of
2 low-volume, isolated rural health care providers partici-
3 pating in the medicare program under title XVIII of the
4 Social Security Act (42 U.S.C. 1395 et seq.).

5 (b) REPORT.—Not later than 18 months after the
6 date of enactment of this Act, MedPAC shall submit a
7 report to the Secretary of Health and Human Services and
8 Congress on the study conducted under subsection (a)
9 indicating—

10 (1) whether low-volume, isolated rural health
11 care providers are having, or may have, significantly
12 decreased medicare margins or other financial dif-
13 ficulties resulting from any of the payment meth-
14 odologies described in subsection (c);

15 (2) whether the status as a low-volume, isolated
16 rural health care provider should be designated
17 under the medicare program and any criteria that
18 should be used to qualify for such a status; and

19 (3) any changes in the payment methodologies
20 described in subsection (c) that are necessary to pro-
21 vide appropriate reimbursement under the medicare
22 program to low-volume, isolated rural health care
23 providers (as designated pursuant to paragraph (2)).

1 (c) PAYMENT METHODOLOGIES DESCRIBED.—The
2 payment methodologies described in this subsection are
3 the following:

4 (1) The prospective payment system for hos-
5 pital outpatient department services under section
6 1833(t) of the Social Security Act (42 U.S.C.
7 1395l).

8 (2) The fee schedule for ambulance services
9 under section 1834(l) of such Act (42 U.S.C.
10 1395m(l)).

11 (3) The prospective payment system for inpa-
12 tient hospital services under section 1886 of such
13 Act (42 U.S.C. 1395ww).

14 (4) The prospective payment system for routine
15 service costs of skilled nursing facilities under sec-
16 tion 1888(e) of such Act (42 U.S.C. 1395yy(e)).

17 (5) The prospective payment system for home
18 health services under section 1895 of such Act (42
19 U.S.C. 1395fff).

1 **TITLE V—PROVISIONS RELAT-**
2 **ING TO PART C**
3 **(MEDICARE+CHOICE PRO-**
4 **GRAM) AND OTHER MEDI-**
5 **CARE MANAGED CARE PROVI-**
6 **SIONS**

7 **SEC. 501. RESTORING EFFECTIVE DATE OF ELECTIONS AND**
8 **CHANGES OF ELECTIONS OF**
9 **MEDICARE+CHOICE PLANS.**

10 (a) OPEN ENROLLMENT.—Section 1851(f)(2) (42
11 U.S.C. 1395w–21(f)(2)) is amended by striking “, except
12 that if such election or change is made after the 10th day
13 of any calendar month, then the election or change shall
14 not take effect until the first day of the second calendar
15 month following the date on which the election or change
16 is made”.

17 (b) EFFECTIVE DATE.—The amendment made by
18 this section shall apply to elections and changes of cov-
19 erage made on or after January 1, 2001.

20 **SEC. 502. SPECIAL MEDIGAP ENROLLMENT ANTIDISCRIMI-**
21 **NATION PROVISION FOR CERTAIN BENE-**
22 **FICIARIES.**

23 (a) DISENROLLMENT WINDOW IN ACCORDANCE
24 WITH BENEFICIARY’S CIRCUMSTANCE.—Section
25 1882(s)(3) (42 U.S.C. 1395ss(s)(3)) is amended—

1 (1) in subparagraph (A), in the matter fol-
2 lowing clause (iii), by striking “, subject to subpara-
3 graph (E), seeks to enroll under the policy not later
4 than 63 days after the date of termination of enroll-
5 ment described in such subparagraph” and inserting
6 “seeks to enroll under the policy during the period
7 specified in subparagraph (E)”; and

8 (2) by striking subparagraph (E) and inserting
9 the following new subparagraph:

10 “(E) For purposes of subparagraph (A), the time pe-
11 riod specified in this subparagraph is—

12 “(i) in the case of an individual described in
13 subparagraph (B)(i), the period beginning on the
14 date the individual receives a notice of termination
15 or cessation of all supplemental health benefits (or,
16 if no such notice is received, notice that a claim has
17 been denied because of such a termination or ces-
18 sation) and ending on the date that is 63 days after
19 the applicable notice;

20 “(ii) in the case of an individual described in
21 clause (ii), (iii), (v), or (vi) of subparagraph (B)
22 whose enrollment is terminated involuntarily, the pe-
23 riod beginning on the date that the individual re-
24 ceives a notice of termination and ending on the

1 date that is 63 days after the date the applicable
2 coverage is terminated;

3 “(iii) in the case of an individual described in
4 subparagraph (B)(iv)(I), the period beginning on the
5 earlier of (I) the date that the individual receives a
6 notice of termination, a notice of the issuer’s bank-
7 ruptcy or insolvency, or other such similar notice, if
8 any, and (II) the date that the applicable coverage
9 is terminated, and ending on the date that is 63
10 days after the date the coverage is terminated;

11 “(iv) in the case of an individual described in
12 clause (ii), (iii), (iv)(II), (iv)(III), (v), or (vi) of sub-
13 paragraph (B) who disenrolls voluntarily, the period
14 beginning on the date that is 60 days before the ef-
15 fective date of the disenrollment and ending on the
16 date that is 63 days after such effective date; and

17 “(v) in the case of an individual described in
18 subparagraph (B) but not described in the preceding
19 provisions of this subparagraph, the period begin-
20 ning on the effective date of the disenrollment and
21 ending on the date that is 63 days after such effec-
22 tive date.”.

23 (b) EXTENDED MEDIGAP ACCESS FOR INTERRUPTED
24 TRIAL PERIODS.—Section 1882(s)(3) (42 U.S.C.

1 1395ss(s)(3)), as amended by subsection (a), is amended
2 by adding at the end the following new subparagraph:

3 “(F) For purposes of this paragraph—

4 “(i) in the case of an individual described in
5 subparagraph (B)(v) (or deemed to be so described,
6 pursuant to this subparagraph) whose enrollment
7 with an organization or provider described in sub-
8 clause (II) of such subparagraph is involuntarily ter-
9 minated within the first 12 months of such enroll-
10 ment, and who, without an intervening enrollment,
11 enrolls with another such organization or provider,
12 such subsequent enrollment shall be deemed to be an
13 initial enrollment described in such subparagraph;
14 and

15 “(ii) in the case of an individual described in
16 clause (vi) of subparagraph (B) (or deemed to be so
17 described, pursuant to this subparagraph) whose en-
18 rollment with a plan or in a program described in
19 clause (v)(II) of such subparagraph is involuntarily
20 terminated within the first 12 months of such enroll-
21 ment, and who, without an intervening enrollment,
22 enrolls in another such plan or program, such subse-
23 quent enrollment shall be deemed to be an initial en-
24 rollment described in clause (vi) of such subpara-
25 graph.”.

1 **SEC. 503. INCREASE IN NATIONAL PER CAPITA**
2 **MEDICARE+CHOICE GROWTH PERCENTAGE**
3 **IN 2001 AND 2002.**

4 Section 1853(c)(6)(B) of the Social Security Act (42
5 U.S.C. 1395w-23(c)(6)(B)) is amended—

6 (1) in clause (iv), by striking “for 2001, 0.5
7 percentage points” and inserting “for 2001, 0 per-
8 centage points”; and

9 (2) in clause (v), by striking “for 2002, 0.3 per-
10 centage points” and inserting “for 2002, 0 percent-
11 age points”.

12 **SEC. 504. ALLOWING MOVEMENT TO 50:50 PERCENT BLEND**
13 **IN 2002.**

14 Section 1853(c)(2) of the Social Security Act (42
15 U.S.C. 1395w-23(c)(2)) is amended—

16 (1) by striking the period at the end of sub-
17 paragraph (F) and inserting a semicolon; and

18 (2) by adding after and below subparagraph
19 (F) the following:

20 “except that a Medicare+Choice organization may
21 elect to apply subparagraph (F) (rather than sub-
22 paragraph (E)) for 2002.”.

1 **SEC. 505. DELAY FROM JULY TO NOVEMBER 2000, IN DEAD-**
 2 **LINE FOR OFFERING AND WITHDRAWING**
 3 **MEDICARE+CHOICE PLANS FOR 2001.**

4 Notwithstanding any other provision of law, the dead-
 5 line for a Medicare+Choice organization to withdraw the
 6 offering of a Medicare+Choice plan under part C of title
 7 XVIII of the Social Security Act (or otherwise to submit
 8 information required for the offering of such a plan) for
 9 2001 is delayed from July 1, 2000, to November 1, 2000,
 10 and any such organization that provided notice of with-
 11 drawal of such a plan during 2000 before the date of en-
 12 actment of this Act may rescind such withdrawal at any
 13 time before November 1, 2000.

14 **SEC. 506. AMOUNTS IN MEDICARE TRUST FUNDS AVAIL-**
 15 **ABLE FOR SECRETARY'S SHARE OF**
 16 **MEDICARE+CHOICE EDUCATION AND EN-**
 17 **ROLLMENT-RELATED COSTS.**

18 (a) RELOCATION OF PROVISIONS.—Section
 19 1857(e)(2) (42 U.S.C. 1395w–27(e)(2)) is amended to
 20 read as follows:

21 “(2) COST-SHARING IN ENROLLMENT-RELATED
 22 COSTS.—A Medicare+Choice organization shall pay
 23 the fee established by the Secretary under section
 24 1851(j)(3)(A).”.

25 (b) FUNDING FOR EDUCATION AND ENROLLMENT
 26 ACTIVITIES.—Section 1851 (42 U.S.C. 1395w–21) is

1 amended by adding at the end the following new sub-
2 section:

3 “(j) FUNDING FOR BENEFICIARY EDUCATION AND
4 ENROLLMENT ACTIVITIES.—

5 “(1) SECRETARY’S ESTIMATE OF TOTAL
6 COSTS.—The Secretary shall annually estimate the
7 total cost for a fiscal year of carrying out this sec-
8 tion, section 4360 of the Omnibus Budget Reconcili-
9 ation Act of 1990 (relating to the health insurance
10 counseling and assistance program), and related ac-
11 tivities.

12 “(2) TOTAL AMOUNT AVAILABLE.—The total
13 amount available to the Secretary for a fiscal year
14 for the costs of the activities described in paragraph
15 (1) shall be equal to the lesser of—

16 “(A) the amount estimated for such fiscal
17 year under paragraph (1); or

18 “(B) for—

19 “(i) fiscal year 2001, \$130,000,000;

20 and

21 “(ii) fiscal year 2002 and each subse-
22 quent fiscal year, the amount for the pre-
23 vious fiscal year, adjusted to account for
24 inflation, any change in the number of

1 beneficiaries under this title, and any other
2 relevant factors.

3 “(3) COST-SHARING IN ENROLLMENT-RELATED
4 COSTS.—

5 “(A) AMOUNTS FROM MEDICARE+CHOICE
6 ORGANIZATIONS.—

7 “(i) IN GENERAL.—The Secretary is
8 authorized to charge a fee to each
9 Medicare+Choice organization with a con-
10 tract under this part that is equal to the
11 organization’s pro rata share (as deter-
12 mined by the Secretary) of the
13 Medicare+Choice portion (as defined in
14 clause (ii)) of the total amount available
15 under paragraph (2) for a fiscal year. Any
16 amounts collected shall be available with-
17 out further appropriation to the Secretary
18 for the costs of the activities described in
19 paragraph (1).

20 “(ii) MEDICARE+CHOICE PORTION
21 DEFINED.—For purposes of clause (i), the
22 term ‘Medicare+Choice portion’ means, for
23 a fiscal year, the ratio, as estimated by the
24 Secretary, of—

1 “(I) the average number of indi-
2 viduals enrolled in Medicare+Choice
3 plans during the fiscal year; to

4 “(II) the average number of indi-
5 viduals entitled to benefits under
6 parts A, and enrolled under part B,
7 during the fiscal year.

8 “(B) SECRETARY’S SHARE.—

9 “(i) AMOUNTS AVAILABLE FROM
10 TRUST FUNDS.—The Secretary’s share of
11 expenses shall be payable from funds in
12 the Federal Hospital Insurance Trust
13 Fund and the Federal Supplementary
14 Medical Insurance Trust Fund, in such
15 proportion as the Secretary shall deem to
16 be fair and equitable after taking into con-
17 sideration the expenses attributable to the
18 administration of this part with respect to
19 part A and B. The Secretary shall make
20 such transfers of moneys between such
21 Trust Funds as may be appropriate to set-
22 tle accounts between the Trust Funds in
23 cases where expenses properly payable
24 from one such Trust Fund have been paid
25 from the other such Trust Fund.

1 “(ii) SECRETARY’S SHARE OF EX-
 2 PENSES DEFINED.—For purposes of clause
 3 (i), the term ‘Secretary’s share of ex-
 4 penses’ means, for a fiscal year, an amount
 5 equal to—

6 “(I) the total amount available to
 7 the Secretary under paragraph (2) for
 8 the fiscal year; less

9 “(II) the amount collected under
 10 subparagraph (A) for the fiscal
 11 year.”.

12 **SEC. 507. REVISED TERMS AND CONDITIONS FOR EXTEN-**
 13 **SION OF MEDICARE COMMUNITY NURSING**
 14 **ORGANIZATION (CNO) DEMONSTRATION**
 15 **PROJECT.**

16 (a) IN GENERAL.—Section 532 of BBRA (42 U.S.C.
 17 1395mm note) is amended—

18 (1) in subsection (a), by striking the second
 19 sentence; and

20 (2) by striking subsection (b) and inserting the
 21 following new subsections:

22 “(b) TERMS AND CONDITIONS.—

23 “(1) JANUARY THROUGH SEPTEMBER 2000.—

24 For the 9-month period beginning with January
 25 2000, any such demonstration project shall be con-

1 ducted under the same terms and conditions as ap-
2 plied to such demonstration during 1999.

3 “(2) OCTOBER 2000 THROUGH DECEMBER
4 2001.—For the 15-month period beginning with Oc-
5 tober 2000, any such demonstration project shall be
6 conducted under the same terms and conditions as
7 applied to such demonstration during 1999, except
8 that the following modifications shall apply:

9 “(A) BASIC CAPITATION RATE.—The basic
10 capitation rate paid for services covered under
11 the project (other than case management serv-
12 ices) per enrollee per month shall be basic capi-
13 tation rate paid for such services for 1999, re-
14 duced by 10 percent in the case of the dem-
15 onstration sites located in Arizona, Minnesota,
16 and Illinois, and 15 percent for the demonstra-
17 tion site located in New York.

18 “(B) TARGETED CASE MANAGEMENT
19 FEE.—A case management fee shall be paid
20 only for enrollees who are classified as ‘mod-
21 erate’ or ‘at risk’ through a baseline health as-
22 sessment (as required for Medicare+Choice
23 plans under section 1852(e) of the Social Secu-
24 rity Act (42 U.S.C. 1395ww–22(e)).

1 “(C) GREATER UNIFORMITY IN CLINICAL
2 FEATURES AMONG SITES.—Each project shall
3 implement for each site—

4 “(i) protocols for periodic telephonic
5 contact with enrollees based on—

6 “(I) the results of such standard-
7 ized written health assessment; and

8 “(II) the application of appro-
9 priate care planning approaches;

10 “(ii) disease management programs
11 for targeted diseases (such as congestive
12 heart failure, arthritis, diabetes, and hy-
13 pertension) that are highly prevalent in the
14 enrolled populations;

15 “(iii) systems and protocols to track
16 enrollees through hospitalizations, includ-
17 ing pre-admission planning, concurrent
18 management during inpatient hospital
19 stays, and post-discharge assessment, plan-
20 ning, and follow-up; and

21 “(iv) standardized patient educational
22 materials for specified diseases and health
23 conditions.

1 “(D) QUALITY IMPROVEMENT.—Each
2 project shall implement at each site once during
3 the 15-month period—

4 “(i) enrollee satisfaction surveys; and
5 “(ii) reporting on specified quality in-
6 dicators for the enrolled population.

7 “(c) EVALUATION.—

8 “(1) PRELIMINARY REPORT.—Not later than
9 July 1, 2001, the Secretary of Health and Human
10 Services shall submit to the Committees on Ways
11 and Means and Commerce of the House of Rep-
12 resentatives and the Committee on Finance of the
13 Senate a preliminary report that—

14 “(A) evaluates such demonstration projects
15 for the period beginning July 1, 1997, and end-
16 ing December 31, 1999, on a site-specific basis
17 with respect to the impact on per beneficiary
18 spending, specific health utilization measures,
19 and enrollee satisfaction; and

20 “(B) includes a similar evaluation of such
21 projects for the portion of the extension period
22 that occurs after September 30, 2000.

23 “(2) FINAL REPORT.—Not later than July 1,
24 2002, the Secretary shall submit a final report to
25 such Committees on such demonstration projects.

1 Such report shall include the same elements as the
2 preliminary report required by paragraph (1), but
3 for the period after December 31, 1999.

4 “(3) METHODOLOGY FOR SPENDING COMPARI-
5 SONS.—Any evaluation of the impact of the dem-
6 onstration projects on per beneficiary spending in-
7 cluded in such reports shall be based on a compari-
8 son of—

9 “(A) data for all individuals who—

10 “(i) were enrolled in such demonstra-
11 tion projects as of the first day of the pe-
12 riod under evaluation; and

13 “(ii) were enrolled for a minimum of
14 6 months thereafter; with

15 “(B) data for a matched sample of individ-
16 uals who are enrolled under part B of title
17 XVIII of the Social Security Act (42 U.S.C.
18 1395j et seq.) and who are not enrolled in such
19 a project, in a Medicare+Choice plan under
20 part C of such title (42 U.S.C. 1395w-21 et
21 seq.), a plan offered by an eligible organization
22 under section 1876 of such Act (42 U.S.C.
23 1395mm), or a health care prepayment plan
24 under section 1833(a)(1)(A) of such Act (42
25 U.S.C. 1395l(a)(1)(A)).”.

1 (b) EFFECTIVE DATE.—The amendments made by
 2 subsection (a) shall be effective as if included in the enact-
 3 ment of section 532 of BBRA (42 U.S.C. 1395mm note).

4 **SEC. 508. MODIFICATION OF PAYMENT RULES FOR CER-**
 5 **TAIN FRAIL ELDERLY MEDICARE BENE-**
 6 **FICIARIES.**

7 (a) MODIFICATION OF PAYMENT RULES.—Section
 8 1853 (42 U.S.C. 1395w–23) is amended—

9 (1) in subsection (a)—

10 (A) in paragraph (1)(A), by striking “sub-
 11 sections (e), (g), and (i)” and inserting “sub-
 12 sections (e), (g), (i), and (j)”;

13 (B) in paragraph (3)(D), by inserting
 14 “paragraph (4) and” after “Subject to”; and

15 (C) by adding at the end the following new
 16 paragraph:

17 “(4) EXEMPTION FROM RISK-ADJUSTMENT SYS-
 18 TEM FOR FRAIL ELDERLY BENEFICIARIES EN-
 19 ROLLED IN SPECIALIZED PROGRAMS.—

20 “(A) IN GENERAL.—In applying the risk-
 21 adjustment factors established under paragraph
 22 (3) during the period described in subparagraph
 23 (B), the limitation under paragraph
 24 (3)(C)(ii)(I) shall apply to a frail elderly
 25 Medicare+Choice beneficiary (as defined in

1 subsection (j)(3)) who is enrolled in a
 2 Medicare+Choice plan under a specialized pro-
 3 gram for the frail elderly (as defined in sub-
 4 section (j)(2)) during the entire period.

5 “(B) PERIOD OF APPLICATION.—The pe-
 6 riod described in this subparagraph begins with
 7 January 2001, and ends with the first month
 8 for which the Secretary certifies to Congress
 9 that a comprehensive risk adjustment method-
 10 ology under paragraph (3)(C) that takes into
 11 account the factors described in subsection
 12 (j)(1)(B) is being fully implemented.”; and
 13 (2) by adding at the end the following new sub-
 14 section:

15 “(j) SPECIAL RULES FOR FRAIL ELDERLY EN-
 16 ROLLED IN SPECIALIZED PROGRAMS FOR THE FRAIL EL-
 17 DERLY.—

18 “(1) DEVELOPMENT AND IMPLEMENTATION OF
 19 NEW PAYMENT SYSTEM.—

20 “(A) IN GENERAL.—The Secretary shall
 21 develop and implement (as soon as possible
 22 after the date of enactment of the Medicare,
 23 Medicaid, and SCHIP Balanced Budget Refine-
 24 ment Act of 2000), during the period described
 25 in subsection (a)(4)(B), a payment methodology

1 for frail elderly Medicare+Choice beneficiaries
2 enrolled in a Medicare+Choice plan under a
3 specialized program for the frail elderly (as de-
4 fined in paragraph (2)(A)).

5 “(B) FACTORS DESCRIBED.—The method-
6 ology developed and implemented under sub-
7 paragraph (A) shall take into account the prev-
8 alence, mix, and severity of chronic conditions
9 among frail elderly Medicare+Choice bene-
10 ficiaries and shall include—

11 “(i) medical diagnostic factors from
12 all provider settings (including hospital
13 and nursing facility settings);

14 “(ii) functional indicators of health
15 status; and

16 “(iii) such other factors as may be
17 necessary to achieve appropriate payments
18 for plans serving such beneficiaries.

19 “(2) SPECIALIZED PROGRAM FOR THE FRAIL
20 ELDERLY DEFINED.—

21 “(A) IN GENERAL.—In this part, the term
22 ‘specialized program for the frail elderly’ means
23 a program that the Secretary determines—

24 “(i) is offered under this part as a
25 distinct part of a Medicare+Choice plan;

1 “(ii) primarily enrolls frail elderly
2 Medicare+Choice beneficiaries; and

3 “(iii) has a clinical delivery system
4 that is specifically designed to serve the
5 special needs of such beneficiaries and to
6 coordinate short-term and long-term care
7 for such beneficiaries through the use of a
8 team described in subparagraph (B) and
9 through the provision of primary care serv-
10 ices to such beneficiaries by means of such
11 a team at the nursing facility involved.

12 “(B) SPECIALIZED TEAM DESCRIBED.—A
13 team described in this subparagraph—

14 “(i) includes—

15 “(I) a physician; and

16 “(II) a nurse practitioner or geri-
17 atric care manager; and

18 “(ii) has as members individuals
19 who—

20 “(I) have special training in the
21 care and management of the frail el-
22 derly beneficiaries; and

23 “(II) specialize in the care and
24 management of such beneficiaries.

1 “(3) FRAIL ELDERLY MEDICARE+CHOICE BEN-
 2 EFICIARY DEFINED.—In this part, the term ‘frail el-
 3 derly Medicare+Choice beneficiary’ means a
 4 Medicare+Choice eligible individual who—

5 “(A) is residing in a skilled nursing facility
 6 (as defined in section 1819(a)) or a nursing fa-
 7 cility (as defined in section 1919(a)) for an in-
 8 definite period and without any intention of re-
 9 siding outside the facility; and

10 “(B) has a severity of condition that
 11 makes the individual frail (as determined under
 12 guidelines approved by the Secretary).”.

13 (b) EFFECTIVE DATE.—The amendments made by
 14 this section shall take effect on the date of enactment of
 15 this Act.

16 **TITLE VI—PROVISIONS RELAT-** 17 **ING TO INDIVIDUALS WITH** 18 **END-STAGE RENAL DISEASE**

19 **SEC. 601. UPDATE IN RENAL DIALYSIS COMPOSITE RATE.**

20 (a) IN GENERAL.—The last sentence of section
 21 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended by strik-
 22 ing “, and for such services” and all that follows before
 23 the period at the end and inserting the following: “, for
 24 such services furnished during 2001, by 2.4 percent above
 25 such composite rate payment amounts for such services

1 furnished on December 31, 2000, for such services fur-
 2 nished during 2002 and 2003, by the percentage increase
 3 in the Consumer Price Index for all urban consumers
 4 (U.S. city average) for the 12-month period ending with
 5 June of the previous year above such composite rate pay-
 6 ment amounts for such services furnished on December
 7 31 of the previous year, and for such services furnished
 8 during a subsequent year, by the ESRD market basket
 9 percentage increase above such composite rate payment
 10 amounts for such services furnished on December 31 of
 11 the previous year”.

12 (b) ESRD MARKET BASKET PERCENTAGE INCREASE
 13 DEFINED.—Section 1881(b) (42 U.S.C. 1395rr(b)) is
 14 amended by adding at the end the following new para-
 15 graph:

16 “(12)(A) For purposes of this title, the term ‘ESRD
 17 market basket percentage increase’ means, with respect to
 18 a calendar year, the percentage (estimated by the Sec-
 19 retary before the beginning of such year) by which—

20 “(i) the cost of the mix of goods and services
 21 included in the provision of dialysis services (which
 22 may include the costs described in subparagraph (D)
 23 as determined appropriate by the Secretary) that is
 24 determined based on an index of appropriately
 25 weighted indicators of changes in wages and prices

1 which are representative of the mix of goods and
2 services included in such dialysis services for the cal-
3 endar year; exceeds

4 “(ii) the cost of such mix of goods and services
5 for the preceding calendar year.

6 “(B) In determining the percentage under subpara-
7 graph (A), the Secretary may take into account any in-
8 crease in the costs of furnishing the mix of goods and serv-
9 ices described in such subparagraph resulting from—

10 “(i) the adoption of scientific and technological
11 innovations used to provide dialysis services; and

12 “(ii) changes in the manner or method of deliv-
13 ering dialysis services.

14 “(C) The Secretary shall periodically review and up-
15 date (as necessary) the items and services included in the
16 mix of goods and services used to determine the percent-
17 age under subparagraph (A).

18 “(D) The costs described in this subparagraph
19 include—

20 “(i) labor, including direct patient care costs
21 and administrative labor costs, vacation and holiday
22 pay, payroll taxes, and employee benefits;

23 “(ii) other direct costs, including drugs, sup-
24 plies, and laboratory fees;

1 “(iii) overhead, including medical director fees,
2 temporary services, general and administrative costs,
3 interest expenses, and bad debt;

4 “(iv) capital, including rent, real estate taxes,
5 depreciation, utilities, repairs, and maintenance; and

6 “(v) such other allowable costs as the Secretary
7 may specify.”.

8 **SEC. 602. REVISION OF PAYMENT RATES FOR ESRD PA-**
9 **TIENTS ENROLLED IN MEDICARE+CHOICE**
10 **PLANS.**

11 (a) IN GENERAL.—Section 1853(a)(1)(B) (42 U.S.C.
12 1395w–23(a)(1)(B)) is amended by adding at the end the
13 following: “In establishing such rates the Secretary shall
14 provide for appropriate adjustments to increase each rate
15 to reflect the demonstration rate (including any risk-ad-
16 justment associated with such rate) of the social health
17 maintenance organization end-stage renal disease dem-
18 onstrations established by section 2355 of the Deficit Re-
19 duction Act of 1984 (Public Law 98–369; 98 Stat. 1103),
20 as amended by section 13567(b) of the Omnibus Budget
21 Reconciliation Act of 1993 (Public Law 103–66; 107 Stat.
22 608), and shall compute such rates by not taking into ac-
23 count individuals with kidney transplants and individuals
24 in which the program under this title is a secondary payer

1 to another payer (or payers) pursuant to section
2 1862(b).”.

3 (b) EFFECTIVE DATE.—The amendment made by
4 subsection (a) shall apply to payments for months begin-
5 ning with January 2002.

6 (c) PUBLICATION.—The Secretary of Health and
7 Human Services, not later than 6 months after the date
8 of enactment of this Act, shall publish for public comment
9 a description of the appropriate adjustments described in
10 the last sentence of section 1853(a)(1)(B) of the Social
11 Security Act (42 U.S.C. 1395w–23(a)(1)(B)), as added by
12 subsection (a). The Secretary shall publish in final form
13 such adjustments by not later than July 1, 2001, so that
14 the amendment made by subsection (a) is implemented on
15 a timely basis consistent with subsection (b).

16 **SEC. 603. PERMITTING ESRD BENEFICIARIES TO ENROLL**
17 **IN ANOTHER MEDICARE+CHOICE PLAN IF**
18 **THE PLAN IN WHICH THEY ARE ENROLLED IS**
19 **TERMINATED.**

20 (a) IN GENERAL.—Section 1851(a)(3)(B) (42 U.S.C.
21 1395w–21(a)(3)(B)) is amended by striking “except that”
22 and all that follows and inserting the following: “except
23 that—

24 “(i) an individual who develops end-
25 stage renal disease while enrolled in a

1 Medicare+Choice plan may continue to be
2 enrolled in that plan; and

3 “(ii) in the case of such an individual
4 who is enrolled in a Medicare+Choice plan
5 under clause (i) (or subsequently under
6 this clause), if the enrollment is discon-
7 tinued under circumstances described in
8 section 1851(e)(4)(A) then the individual
9 will be treated as a ‘Medicare+Choice eli-
10 gible individual’ for purposes of electing to
11 continue enrollment in another
12 Medicare+Choice plan.”.

13 (b) EFFECTIVE DATE.—

14 (1) IN GENERAL.—The amendment made by
15 subsection (a) shall apply to terminations and
16 discontinuations occurring on or after the date of
17 enactment of this Act.

18 (2) APPLICATION TO PRIOR PLAN TERMI-
19 NATIONS.—Clause (ii) of section 1851(a)(3)(B) of
20 the Social Security Act (as inserted by subsection
21 (a)) also shall apply to individuals whose enrollment
22 in a Medicare+Choice plan was terminated or dis-
23 continued after December 31, 1997, and before the
24 date of enactment of this Act. In applying this para-
25 graph, such an individual shall be treated, for pur-

1 poses of part C of title XVIII of the Social Security
2 Act, as having discontinued enrollment in such a
3 plan as of the date of enactment of this Act.

4 **SEC. 604. COVERAGE OF CERTAIN VASCULAR ACCESS SERV-**
5 **ICES FOR ESRD BENEFICIARIES PROVIDED**
6 **BY AMBULATORY SURGICAL CENTERS.**

7 (a) IN GENERAL.—The matter following subpara-
8 graph (B) of section 1833(i)(1) (42 U.S.C. 1395l(i)(1))
9 is amended by adding at the end the following new sen-
10 tence: “Such lists shall include the procedures identified
11 as of July 30, 1999, by vascular access codes 34101,
12 34111, 34490, 35190, 35458, 35460, 35475, 35476,
13 35903, 36005, 36010, 36011, 36120, 36140, 36145,
14 36215–36218, 36831–36834, 37201, 37204–37208,
15 37250, 37251, and 49423.”.

16 (b) EFFECTIVE DATE.—The amendment made by
17 subsection (a) shall apply to vascular access services fur-
18 nished on or after January 1, 2000.

19 **SEC. 605. COLLECTION AND ANALYSIS OF INFORMATION**
20 **ON THE SATISFACTION OF ESRD BENE-**
21 **FICIARIES WITH THE QUALITY OF AND AC-**
22 **CESS TO HEALTH CARE UNDER THE MEDI-**
23 **CARE PROGRAM.**

24 (a) COLLECTION OF INFORMATION.—The Secretary
25 shall collect information on the satisfaction of each ESRD

1 medicare beneficiary with the quality of health care under
2 the original fee-for-service medicare program and the
3 Medicare+Choice program, and the access of each bene-
4 ficiary to that care.

5 (b) ANALYSIS OF COLLECTED INFORMATION.—

6 (1) IN GENERAL.—The Secretary shall conduct
7 an analysis of the information collected under sub-
8 section (a) to determine—

9 (A) the kinds of health care that each non-
10 dialysis health care provider provides to each
11 ESRD medicare beneficiary for the treatment
12 of end-stage renal disease and each comor-
13 bidity;

14 (B) the effect of the availability of supple-
15 mental insurance on the use by beneficiary of
16 health care;

17 (C) the perceptions of each beneficiary re-
18 garding the access of that beneficiary to health
19 care; and

20 (D) the quality of health care provided to
21 each ESRD medicare beneficiary enrolled under
22 the Medicare+Choice program compared to
23 each beneficiary enrolled under the original fee-
24 for-service medicare program.

1 (2) CONSIDERATIONS.—In conducting the anal-
2 ysis under paragraph (1), the Secretary shall
3 consider—

4 (A) the feasibility of routinely collecting in-
5 formation on the satisfaction of each ESRD
6 medicare beneficiary with dialysis and non-di-
7 alysis health care;

8 (B) whether to collect information using
9 disease specific questions or generic questions
10 (similar to those used in conducting the Medi-
11 care Current Beneficiary Survey);

12 (C) how well collected information detects
13 access problems within each specific group of
14 ESRD medicare beneficiaries, including bene-
15 ficiaries without supplemental insurance and
16 beneficiaries that reside in a rural area; and

17 (D) each obstacle that a health care pro-
18 vider may face in offering each type of dialysis
19 service.

20 (c) AVAILABILITY OF INFORMATION AND ANAL-
21 YSIS.—Not later than January 1 of each year (beginning
22 in 2002) the Secretary shall make the information col-
23 lected under subsection (a) and the analysis conducted
24 under subsection (b) available to the public.

25 (d) DEFINITIONS.—In this section:

1 (1) ESRD MEDICARE BENEFICIARY.—The term
2 “ESRD medicare beneficiary” means an individual
3 eligible for benefits under the medicare program that
4 has end-stage renal disease (including an individual
5 enrolled in a Medicare+Choice plan offered by a
6 Medicare+Choice organization under the
7 Medicare+Choice program).

8 (2) MEDICARE+CHOICE PROGRAM.—The term
9 “Medicare+Choice program” means the program es-
10 tablished under part C of title XVIII of the Social
11 Security Act (42 U.S.C. 1395w–21 et seq.).

12 (3) ORIGINAL FEE-FOR-SERVICE MEDICARE
13 PROGRAM.—The term “original fee-for-service medi-
14 care program” means the health benefits program
15 under parts A and B title XVIII of the Social Secu-
16 rity Act (42 U.S.C. 1395 et seq.).

17 (4) SECRETARY.—The term “Secretary” means
18 the Secretary of Health and Human Services, acting
19 through the Administrator of the Health Care Fi-
20 nancing Administration.

1 **TITLE VII—ACCESS TO CARE IM-**
 2 **PROVEMENTS THROUGH**
 3 **MEDICAID AND SCHIP**

4 **SEC. 701. NEW PROSPECTIVE PAYMENT SYSTEM FOR FED-**
 5 **ERALLY-QUALIFIED HEALTH CENTERS AND**
 6 **RURAL HEALTH CLINICS.**

7 (a) IN GENERAL.—Section 1902(a) (42 U.S.C.
 8 1396a(a)) is amended—

9 (1) in paragraph (13)—

10 (A) in subparagraph (A), by adding “and”
 11 at the end;

12 (B) in subparagraph (B), by striking
 13 “and” at the end; and

14 (C) by striking subparagraph (C); and

15 (2) by inserting after paragraph (14) the fol-
 16 lowing new paragraph:

17 “(15) for payment for services described in sub-
 18 paragraph (B) or (C) of section 1905(a)(2) under
 19 the plan in accordance with subsection (aa);”.

20 (b) NEW PROSPECTIVE PAYMENT SYSTEM.—Section
 21 1902 (42 U.S.C. 1396a) is amended by adding at the end
 22 the following:

23 “(aa) PAYMENT FOR SERVICES PROVIDED BY FED-
 24 ERALLY-QUALIFIED HEALTH CENTERS AND RURAL
 25 HEALTH CLINICS.—

1 “(1) IN GENERAL.—Beginning with fiscal year
2 2001 and each succeeding fiscal year, the State plan
3 shall provide for payment for services described in
4 section 1905(a)(2)(C) furnished by a Federally-
5 qualified health center and services described in sec-
6 tion 1905(a)(2)(B) furnished by a rural health clinic
7 in accordance with the provisions of this subsection.

8 “(2) FISCAL YEAR 2001.—Subject to paragraph
9 (4), for services furnished during fiscal year 2001,
10 the State plan shall provide for payment for such
11 services in an amount (calculated on a per visit
12 basis) that is equal to 100 percent of the costs of
13 the center or clinic of furnishing such services dur-
14 ing fiscal year 2000 which are reasonable and re-
15 lated to the cost of furnishing such services, or
16 based on such other tests of reasonableness as the
17 Secretary prescribes in regulations under section
18 1833(a)(3), or, in the case of services to which such
19 regulations do not apply, the same methodology used
20 under section 1833(a)(3), adjusted to take into ac-
21 count any increase in the scope of such services fur-
22 nished by the center or clinic during fiscal year
23 2001.

24 “(3) FISCAL YEAR 2002 AND SUCCEEDING FIS-
25 CAL YEARS.—Subject to paragraph (4), for services

1 furnished during fiscal year 2002 or a succeeding
2 fiscal year, the State plan shall provide for payment
3 for such services in an amount (calculated on a per
4 visit basis) that is equal to the amount calculated for
5 such services under this subsection for the preceding
6 fiscal year—

7 “(A) increased by the percentage increase
8 in the MEI (as defined in section 1842(i)(3))
9 applicable to primary care services (as defined
10 in section 1842(i)(4)) for that fiscal year; and

11 “(B) adjusted to take into account any in-
12 crease in the scope of such services furnished by
13 the center or clinic during that fiscal year.

14 “(4) ESTABLISHMENT OF INITIAL YEAR PAY-
15 MENT AMOUNT FOR NEW CENTERS OR CLINICS.—In
16 any case in which an entity first qualifies as a Fed-
17 erally-qualified health center or rural health clinic
18 after fiscal year 2000, the State plan shall provide
19 for payment for services described in section
20 1905(a)(2)(C) furnished by the center or services
21 described in section 1905(a)(2)(B) furnished by the
22 clinic in the first fiscal year in which the center or
23 clinic so qualifies in an amount (calculated on a per
24 visit basis) that is equal to 100 percent of the costs
25 of furnishing such services during such fiscal year in

1 accordance with the regulations and methodology re-
2 ferred to in paragraph (2). For each fiscal year fol-
3 lowing the fiscal year in which the entity first quali-
4 fies as a Federally-qualified health center or rural
5 health clinic, the State plan shall provide for the
6 payment amount to be calculated in accordance with
7 paragraph (3).

8 “(5) ADMINISTRATION IN THE CASE OF MAN-
9 AGED CARE.—In the case of services furnished by a
10 Federally-qualified health center or rural health clin-
11 ic pursuant to a contract between the center or clinic
12 and a managed care entity (as defined in section
13 1932(a)(1)(B)), the State plan shall provide for pay-
14 ment to the center or clinic (at least quarterly) by
15 the State of a supplemental payment equal to the
16 amount (if any) by which the amount determined
17 under paragraphs (2), (3), and (4) of this subsection
18 exceeds the amount of the payments provided under
19 the contract.

20 “(6) ALTERNATIVE PAYMENT METHODOLO-
21 GIES.—Notwithstanding any other provision of this
22 section, the State plan may provide for payment in
23 any fiscal year to a Federally-qualified health center
24 for services described in section 1905(a)(2)(C) or to
25 a rural health clinic for services described in section

1 1905(a)(2)(B) in an amount which is determined
2 under an alternative payment methodology that—

3 “(A) is agreed to by the State and the cen-
4 ter or clinic; and

5 “(B) results in payment to the center or
6 clinic of an amount which is at least equal to
7 the amount otherwise required to be paid to the
8 center or clinic under this section.”.

9 (c) CONFORMING AMENDMENTS.—

10 (1) Section 4712 of BBA (111 Stat. 508) is
11 amended by striking subsection (c).

12 (2) Section 1915(b) (42 U.S.C. 1396n(b)) is
13 amended by striking “1902(a)(13)(E)” and insert-
14 ing “1902(a)(15), 1902(aa),”.

15 (d) EFFECTIVE DATE.—The amendments made by
16 this section take effect on October 1, 2000, and apply to
17 services furnished on or after such date.

18 **SEC. 702. TRANSITIONAL MEDICAL ASSISTANCE.**

19 (a) MAKING PROVISION PERMANENT.—

20 (1) IN GENERAL.—Subsection (f) of section
21 1925 (42 U.S.C. 1396r–6) is repealed.

22 (2) CONFORMING AMENDMENT.—Section
23 1902(e)(1) (42 U.S.C. 1396a(e)(1)) is repealed.

1 (b) STATE OPTION OF INITIAL 12-MONTH ELIGI-
 2 BILITY.—Section 1925 (42 U.S.C. 1396r–6) is
 3 amended—

4 (1) in subsection (a), by adding at the end the
 5 following new paragraph:

6 “(5) OPTION OF 12-MONTH INITIAL ELIGIBILITY
 7 PERIOD.—A State may elect to treat any reference
 8 in this subsection to a 6-month period (or 6 months)
 9 as a reference to a 12-month period (or 12 months).
 10 In the case of such an election, subsection (b) shall
 11 not apply.”; and

12 (2) in subsection (b)(1), by inserting “and sub-
 13 section (a)(5)” after “paragraph (3)”.

14 (c) SIMPLIFICATION OPTIONS.—

15 (1) REMOVAL OF ADMINISTRATIVE REPORTING
 16 REQUIREMENTS FOR ADDITIONAL 6-MONTH EXTEN-
 17 SION.—Section 1925(b) (42 U.S.C. 1396r–6(b)) is
 18 amended—

19 (A) in paragraph (2)—

20 (i) in the heading, by striking “AND
 21 REPORTING”;

22 (ii) by striking subparagraph (B);

23 (iii) in subparagraph (A)(i)—

1 (I) by striking “(I)” and all that
2 follows through “(II)” and inserting
3 “(i)”;

4 (II) by striking “, and (III)” and
5 inserting “and (ii)”;

6 (III) by redesignating such sub-
7 paragraph as subparagraph (A) (with
8 appropriate indentation); and
9 (iv) in subparagraph (A)(ii)—

10 (I) by striking “notify the family
11 of the reporting requirement under
12 subparagraph (B)(ii) and a statement
13 of” and inserting “provide the family
14 with notification of”; and

15 (II) by redesignating such sub-
16 paragraph as subparagraph (B) (with
17 appropriate indentation);

18 (B) in paragraph (3)(A)—

19 (i) in clause (iii)—

20 (I) in the heading, by striking
21 “REPORTING AND TEST”;

22 (II) by striking subclause (I);
23 and

1 (III) by redesignating subclauses
2 (II) and (III) as subclauses (I) and
3 (II), respectively; and
4 (ii) by striking the last 3 sentences;
5 and
6 (C) in paragraph (3)(B), by striking “sub-
7 paragraph (A)(iii)(II)” and inserting “subpara-
8 graph (A)(iii)(I)”.

9 (2) EXEMPTION FOR STATES COVERING NEEDY
10 FAMILIES UP TO 185 PERCENT OF POVERTY.—Sec-
11 tion 1925 (42 U.S.C. 1396r–6), as amended by sub-
12 section (a), is amended—

13 (A) in each of subsections (a)(1) and
14 (b)(1), by inserting “but subject to subsection
15 (f),” after “Notwithstanding any other provi-
16 sion of this title,”; and

17 (B) by adding at the end the following new
18 subsection:

19 “(f) EXEMPTION FOR STATE COVERING NEEDY
20 FAMILIES UP TO 185 PERCENT OF POVERTY.—At State
21 option, the provisions of this section shall not apply to a
22 State that uses the authority under section 1931(b)(2)(C)
23 to make medical assistance available under the State plan
24 under this title, at a minimum, to all individuals described
25 in section 1931(b)(1) in families with gross incomes (de-

1 terminated without regard to work-related child care ex-
 2 penses of such individuals) at or below 185 percent of the
 3 income official poverty line (as defined by the Office of
 4 Management and Budget, and revised annually in accord-
 5 ance with section 673(2) of the Omnibus Budget Rec-
 6 onciliation Act of 1981) applicable to a family of the size
 7 involved.”.

8 (3) STATE OPTION TO ELECT SHORTER PERIOD
 9 FOR REQUIREMENT FOR RECEIPT OF MEDICAL AS-
 10 SISTANCE AS A CONDITION OF ELIGIBILITY FOR
 11 TRANSITIONAL MEDICAL ASSISTANCE.—Section
 12 1925(a)(1) (42 U.S.C. 1396r–6(a)(1)) is amended
 13 by inserting “(or such shorter period as the State
 14 may elect)” after “3”.

15 (d) APPLICATION OF NOTICE OF ELIGIBILITY TO
 16 ALL FAMILIES LEAVING WELFARE.—Section 1925(a) (42
 17 U.S.C. 1396r–6(a)), as amended by subsection (b)(1), is
 18 amended by adding at the end the following new para-
 19 graph:

20 “(6) NOTICE OF ELIGIBILITY FOR MEDICAL AS-
 21 SISTANCE TO ALL FAMILIES LEAVING TANF.—Each
 22 State shall notify each family which was receiving
 23 assistance under the State program funded under
 24 part A of title IV and which is no longer eligible for
 25 such assistance, of the potential eligibility of the

1 family and any individual members of such family
2 for medical assistance under this title or child health
3 assistance under title XXI. Such notice shall include
4 a statement that the family does not have to be re-
5 ceiving assistance under the State program funded
6 under part A of title IV in order to be eligible for
7 such medical assistance or child health assistance.”.

8 (e) ENROLLMENT DATA.—Section 1925 (42 U.S.C.
9 1396r–6), as amended by subsection (c)(2)(B), is amend-
10 ed by adding at the end the following new subsection:

11 “(g) ENROLLMENT DATA.—The Secretary annually
12 shall obtain from each State with a State plan approved
13 under this title enrollment data regarding—

14 “(1) the number of adults and children who—

15 “(A) receive medical assistance under this
16 title based on eligibility under section 1931;

17 “(B) at the time they were first deter-
18 mined to be eligible for such medical assistance,
19 also received cash assistance under the State
20 program funded under part A of title IV; and

21 “(C) subsequently ceased to receive assist-
22 ance under such State program due to in-
23 creased earnings or increased child support in-
24 come;

1 “(2) the percentage of the adults and children
2 described in paragraph (1) who receive transitional
3 medical assistance under this section or otherwise
4 remain enrolled in the program under this title; and

5 “(3) the percentage of such adults and children
6 that receive such transitional medical assistance for
7 more than 6 months or that remain enrolled in the
8 program under this title for more than 6 months
9 after such adults or children ceased to receive assist-
10 ance under the State program funded under part A
11 of title IV.”.

12 (f) EFFECTIVE DATE.—The amendments made by
13 this section take effect on October 1, 2000.

14 **SEC. 703. APPLICATION OF SIMPLIFIED SCHIP PROCE-**
15 **DURES UNDER THE MEDICAID PROGRAM.**

16 (a) COORDINATION WITH MEDICAID.—

17 (1) IN GENERAL.—Section 1902(l) (42 U.S.C.
18 1396a(l)) is amended—

19 (A) in paragraph (3), by inserting “subject
20 to paragraph (5)”, after “Notwithstanding sub-
21 section (a)(17),”; and

22 (B) by adding at the end the following new
23 paragraph:

24 “(5) With respect to determining the eligibility of in-
25 dividuals under 19 years of age for medical assistance

1 under subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI),
2 (a)(10)(A)(i)(VII), (a)(10)(A)(ii)(IX), or
3 (a)(10)(A)(ii)(XIV), notwithstanding any other provision
4 of this title, if the State has established a State child
5 health plan under title XXI, or expanded coverage beyond
6 the income eligibility standards required for such individ-
7 uals under this title under a waiver granted under section
8 1115—

9 “(A) the State may not apply a resource stand-
10 ard if the State does not apply such a standard
11 under such child health plan or section 1115 waiver
12 with respect to such individuals;

13 “(B) the State shall use the same simplified eli-
14 gibility form (including, if applicable, permitting ap-
15 plication other than in person) as the State uses
16 under such State child health plan or section 1115
17 waiver with respect to such individuals;

18 “(C) the State shall provide for initial eligibility
19 determinations and redeterminations of eligibility
20 using the same verification policies, forms, and fre-
21 quency as the State uses for such purposes under
22 such State child health plan or section 1115 waiver
23 with respect to such individuals; and

24 “(D) the State shall not require a face-to-face
25 interview for purposes of initial eligibility determina-

1 tions and redeterminations unless the State required
2 such an interview for such purposes under such child
3 health plan or section 1115 waiver with respect to
4 such individuals.”.

5 (2) EFFECTIVE DATE.—The amendments made
6 by paragraph (1) take effect on October 1, 2000,
7 and apply to eligibility determinations and redeter-
8 minations made on or after such date.

9 (b) AUTOMATIC REASSESSMENT OF ELIGIBILITY FOR
10 TITLE XXI AND MEDICAID BENEFITS FOR CHILDREN
11 LOSING MEDICAID OR TITLE XXI ELIGIBILITY.—

12 (1) LOSS OF MEDICAID ELIGIBILITY.—Section
13 1902(a) of the Social Security Act (42 U.S.C.
14 1396a(a)) is amended—

15 (A) by striking the period at the end of
16 paragraph (65) and inserting “; and”, and

17 (B) by inserting after paragraph (65) the
18 following new paragraph:

19 “(66) provide, by not later than the first day of
20 the first month that begins more than 1 year after
21 the date of the enactment of this paragraph and in
22 the case of a State with a State child health plan
23 under title XXI, that before medical assistance to a
24 child (or a parent of a child) is discontinued under
25 this title, a determination of whether the child (or

parent) is eligible for benefits under title XXI shall be made and, if determined to be so eligible, the child (or parent) shall be automatically enrolled in the program under such title without the need for a new application and without being asked to provide any information that is already available to the State.”.

(2) LOSS OF TITLE XXI ELIGIBILITY.—Section 2102(b)(3) (42 U.S.C. 1397bb(b)(3)) is amended by redesignating subparagraphs (D) and (E) as subparagraphs (E) and (F), respectively, and by inserting after subparagraph (C) the following new subparagraph:

“(D) that before health assistance to a child (or a parent of a child) is discontinued under this title, a determination of whether the child (or parent) is eligible for benefits under title XIX is made and, if determined to be so eligible, the child (or parent) is automatically enrolled in the program under such title without the need for a new application and without being asked to provide any information that is already available to the State;”.

(3) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) apply to individuals who

1 lose eligibility under the medicaid program under
2 title XIX, or under a State child health insurance
3 plan under title XXI, respectively, of the Social Se-
4 curity Act (42 U.S.C. 1396 et seq.; 1397aa et seq.)
5 on or after the date that is 60 days after the date
6 of the enactment of this Act.

7 **SEC. 704. PRESUMPTIVE ELIGIBILITY.**

8 (a) ADDITIONAL ENTITIES QUALIFIED TO DETER-
9 MINE PRESUMPTIVE ELIGIBILITY FOR LOW-INCOME
10 CHILDREN.—

11 (1) MEDICAID.—Section 1920A(b)(3)(A)(i) (42
12 U.S.C. 1396r-1a(b)(3)(A)(i)) is amended—

13 (A) by striking “or (II)” and inserting “,
14 (II)”; and

15 (B) by inserting “eligibility of a child for
16 medical assistance under the State plan under
17 this title, or eligibility of a child for child health
18 assistance under the program funded under
19 title XXI, (III) is an elementary school or sec-
20 ondary school, as such terms are defined in sec-
21 tion 14101 of the Elementary and Secondary
22 Education Act of 1965 (20 U.S.C. 8801), an el-
23 ementary or secondary school operated or sup-
24 ported by the Bureau of Indian Affairs, a State
25 child support enforcement agency, a child care

resource and referral agency, an organization that is providing emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act, or a State office or entity involved in enrollment in the program under this title, under part A of title IV, under title XXI, or that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437 et seq.), or (IV) any other entity the State so deems, as approved by the Secretary” before the semicolon.

(2) APPLICATION UNDER SCHIP.—

(A) IN GENERAL.—Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)) is amended by adding at the end the following new subparagraph:

“(D) Section 1920A (relating to presumptive eligibility).”.

(B) EXCEPTION FROM LIMITATION ON ADMINISTRATIVE EXPENSES.—Section 2105(c)(2) (42 U.S.C. 1397ee(c)(2)) is amended by adding at the end the following new subparagraph:

1 “(C) EXCEPTION FOR PRESUMPTIVE ELI-
 2 GIBILITY EXPENDITURES.—The limitation
 3 under subparagraph (A) on expenditures shall
 4 not apply to expenditures attributable to the
 5 application of section 1920A (pursuant to sec-
 6 tion 2107(e)(1)(D)), regardless of whether the
 7 child is determined to be ineligible for the pro-
 8 gram under this title or title XIX.”.

9 (3) TECHNICAL AMENDMENTS.—Section 1920A
 10 (42 U.S.C. 1396r–1a) is amended—

11 (A) in subsection (b)(3)(A)(ii), by striking
 12 “paragraph (1)(A)” and inserting “paragraph
 13 (2)(A)”;

14 (B) in subsection (c)(2), in the matter pre-
 15 ceding subparagraph (A), by striking “sub-
 16 section (b)(1)(A)” and inserting “subsection
 17 (b)(2)(A)”.

18 (b) ELIMINATION OF SCHIP FUNDING OFFSET FOR
 19 EXERCISE OF PRESUMPTIVE ELIGIBILITY OPTION.—

20 (1) IN GENERAL.—Section 2104(d) (42 U.S.C.
 21 1397dd(d)) is amended by striking “the sum of—”
 22 and all that follows through “(2)” and conforming
 23 the margins of all that remains accordingly.

24 (2) EFFECTIVE DATE.—The amendment made
 25 by paragraph (1) takes effect October 1, 2000, and

1 applies to allotments under title XXI of the Social
2 Security Act (42 U.S.C. 1397aa et seq.) for fiscal
3 year 2001 and each succeeding fiscal year there-
4 after.

5 **SEC. 705. IMPROVEMENTS TO THE MATERNAL AND CHILD**
6 **HEALTH SERVICES BLOCK GRANT.**

7 (a) INCREASE IN AUTHORIZATION OF APPROPRIA-
8 TIONS.—Section 501(a) (42 U.S.C. 701(a)) is amended in
9 the matter preceding paragraph (1) by striking
10 “\$705,000,000 for fiscal year 1994” and inserting
11 “\$1,000,000,000 for fiscal year 2001”.

12 (b) COORDINATION WITH MEDICAID AND SCHIP.—

13 (1) SCHIP.—Section 505(a)(5)(F) (42 U.S.C.
14 705(a)(5)(F)) is amended—

15 (A) in clause (ii), by inserting “and in the
16 coordination of the administration of the State
17 program under title XXI with the care and
18 services available under this title, as required
19 under subsections (b)(3)(G) and (c)(2) of sec-
20 tion 2102” before the comma; and

21 (B) in clause (iv), by striking “and infants
22 who are eligible for medical assistance under
23 subparagraph (A) or (B) of section 1902(l)(1)”
24 and inserting “, infants, and children who are
25 eligible for medical assistance under section

1 1902(l)(1), and children who are eligible for
2 child health assistance under the State program
3 under title XXI”.

4 (2) CONFORMING AMENDMENTS TO SCHIP.—
5 Section 2102(b)(3) (42 U.S.C. 1397bb(b)(3)), as
6 amended by section 703(b)(2), is amended—

7 (A) by striking “and” at the end of sub-
8 paragraph (E);

9 (B) by striking the period at the end of
10 subparagraph (F) and inserting “; and”; and

11 (C) by adding at the end the following new
12 subparagraph:

13 “(G) that operations and activities under
14 this title are developed and implemented in con-
15 sultation and coordination with the program op-
16 erated by the State under title V with respect
17 to outreach and enrollment, benefits and serv-
18 ices, service delivery standards, public health
19 and social service agency relationships, and
20 quality assurance and data reporting.”.

21 (c) EFFECTIVE DATE.—The amendments made by
22 this section take effect on October 1, 2000.

1 **SEC. 706. IMPROVING ACCESS TO MEDICARE COST-SHAR-**
2 **ING ASSISTANCE FOR LOW-INCOME BENE-**
3 **FICIARIES.**

4 (a) INCREASE IN SLMB ELIGIBILITY.—

5 (1) IN GENERAL.—Section 1902(a)(10)(E) (42
6 U.S.C. 1396a(a)(10)(E)) is amended—

7 (A) in clause (iii), by striking “and 120
8 percent in 1995” and inserting “, 120 percent
9 in 1995 through 2000, and 135 percent in
10 2001”; and

11 (B) in clause (iv), by striking “2002)—”
12 and all that follows through “(II) for” and in-
13 serting “2002) for”.

14 (2) CONFORMING AMENDMENT.—Section
15 1933(c)(2)(A) (42 U.S.C. 1396u–3(c)(2)(A)) is
16 amended by striking “sum of—” and all that follows
17 through “(ii) the”.”.

18 (3) EFFECTIVE DATE.—The amendments made
19 by this subsection take effect on January 1, 2001,
20 and with respect to the amendment made by para-
21 graph (2), applies to allocations determined under
22 section 1933(c) of the Social Security Act (42
23 U.S.C. 1396u–3(c)) for the last 3 quarters of fiscal
24 year 2001 and all of fiscal year 2002.

25 (b) INDEX OF ASSETS TEST TO INFLATION.—Section
26 1905(p)(1)(C) (42 U.S.C. 1396d(p)(1)(C)) is amended by

1 inserting “, increased (beginning with 2001 and each year
 2 thereafter) by the percentage increase (if any) in the Con-
 3 sumer Price Index for All Urban Consumers (United
 4 States city average)” before the period.

5 (c) INCREASED EFFORT TO PROVIDE MEDICARE
 6 BENEFICIARIES WITH MEDICARE COST-SHARING UNDER
 7 THE MEDICAID PROGRAM.—

8 (1) IN GENERAL.—Section 1902(a) (42 U.S.C.
 9 1396a(a)), as amended by section 703(b)(1)(A), is
 10 amended—

11 (A) in paragraph (65), by striking “and”
 12 at the end;

13 (B) in paragraph (66), by striking the pe-
 14 riod and inserting “; and”; and

15 (C) by inserting after paragraph (66) the
 16 following new paragraph:

17 “(67) provide for the determination of eligibility
 18 for medicare cost-sharing (as defined in section
 19 1905(p)(3)) for individuals described in paragraph
 20 (10)(E) and, if eligible for such medicare cost-shar-
 21 ing, for the enrollment of such individuals at any
 22 hospital, clinic, or similar entity at which State or
 23 local agency personnel are stationed for the purpose
 24 of determining the eligibility of individuals for med-
 25 ical assistance under the State plan or providing

1 outreach services to eligible or potentially eligible in-
 2 dividuals.”.

3 (2) EFFECTIVE DATE.—The amendments made
 4 by this paragraph shall take effect on the date of en-
 5 actment of this Act.

6 (d) PRESUMPTIVE ELIGIBILITY OF CERTAIN LOW-IN-
 7 COME INDIVIDUALS FOR MEDICARE COST-SHARING
 8 UNDER THE QMB OR SLMB PROGRAM.—Title XIX (42
 9 U.S.C. 1396 et seq.) is amended by inserting after section
 10 1920A the following new section:

11 “PRESUMPTIVE ELIGIBILITY OF CERTAIN LOW-INCOME
 12 INDIVIDUALS

13 “SEC. 1920B. (a) A State plan approved under sec-
 14 tion 1902 shall provide for making medical assistance with
 15 respect to medicare cost-sharing covered under the State
 16 plan available to a low-income individual on the date the
 17 low-income individual becomes entitled to benefits under
 18 part A of title XVIII during a presumptive eligibility pe-
 19 riod.

20 “(b) For purposes of this section:

21 “(1) The term ‘low-income individual’ means an
 22 individual who at the age of 65 years is described—

23 “(A) in section 1902(a)(10)(E)(i), or

24 “(B) in section 1902(a)(10)(E)(iii).

25 “(2) The term ‘medicare cost-sharing’—

1 “(A) with respect to an individual de-
2 scribed in paragraph (1)(A), has the meaning
3 given such term in section 1905(p)(3); and

4 “(B) with respect to an individual de-
5 scribed in paragraph (1)(B), has the meaning
6 given such term in section 1905(p)(3)(A).

7 “(3) The term ‘presumptive eligibility period’
8 means, with respect to a low-income individual, the
9 period that—

10 “(A) begins with the date on which a
11 qualified entity determines, on the basis of pre-
12 liminary information, that the income and re-
13 sources of the individual do not exceed the ap-
14 plicable income and resource level of eligibility
15 under the State plan, and

16 “(B) ends with (and includes) the earlier
17 of—

18 “(i) the day on which a determination
19 is made with respect to the eligibility of
20 the low-income individual for medical as-
21 sistance for medical cost-sharing under the
22 State plan, or

23 “(ii) in the case of a low-income indi-
24 vidual on whose behalf an application is
25 not filed by the last day of the month fol-

1 lowing the month during which the entity
2 makes the determination referred to in
3 subparagraph (A), such last day.

4 “(4)(A) Subject to subparagraph (B), the term
5 ‘qualified entity’ means any of the following:

6 “(i) Qualified individuals within the Social
7 Security Administration.

8 “(ii) An entity determined by the State
9 agency to be capable of making determinations
10 of the type described in paragraph (3).

11 “(B) The Secretary may issue regulations fur-
12 ther limiting those entities that may become quali-
13 fied entities in order to prevent fraud and abuse and
14 for other reasons.

15 “(c)(1) The State agency, after consultation with the
16 Secretary, shall provide qualified entities with—

17 “(A) such forms as are necessary for an appli-
18 cation to be made on behalf of a low-income indi-
19 vidual for medical assistance for medical cost-shar-
20 ing under the State plan, and

21 “(B) information on how to assist low-income
22 individuals and other persons in completing and fil-
23 ing such forms.

24 “(2) A qualified entity that determines under sub-
25 section (b)(2)(A) that a low-income individual is presump-

1 tively eligible for medical assistance for medical cost-shar-
2 ing under a State plan shall—

3 “(A) notify the State agency of the determina-
4 tion within 5 working days after the date on which
5 the determination is made, and

6 “(B) inform the low-income individual at the
7 time the determination is made that an application
8 for medical assistance for medical cost-sharing under
9 the State plan is required to be made by not later
10 than the last day of the month following the month
11 during which the determination is made.

12 “(3) In the case of a low-income individual who is
13 determined by a qualified entity to be presumptively eligi-
14 ble for medical assistance for medical cost-sharing under
15 a State plan, the low-income individual shall make applica-
16 tion for medical assistance for medical cost-sharing under
17 such plan by not later than the last day of the month fol-
18 lowing the month during which the determination is made.

19 “(d) Notwithstanding any other provision of this title,
20 medical assistance for medicare cost-sharing that—

21 “(1) is furnished to a low-income individual
22 during a presumptive eligibility period under the
23 State plan; and

24 “(2) is included in the services covered by a
25 State plan;

1 shall be treated as medical assistance provided by such
2 plan for purposes of section 1903.”.

3 **SEC. 707. BREAST AND CERVICAL CANCER PREVENTION**
4 **AND TREATMENT.**

5 (a) COVERAGE AS OPTIONAL CATEGORICALLY
6 NEEDY GROUP.—

7 (1) IN GENERAL.—Section 1902(a)(10)(A)(ii)
8 (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

9 (A) in subclause (XVI), by striking “or” at
10 the end;

11 (B) in subclause (XVII), by adding “or” at
12 the end; and

13 (C) by adding at the end the following:

14 “(XVIII) who are described in
15 subsection (aa) (relating to certain
16 breast or cervical cancer patients);”.

17 (2) GROUP DESCRIBED.—Section 1902 (42
18 U.S.C. 1396a) is amended by adding at the end the
19 following:

20 “(aa) Individuals described in this subsection are in-
21 dividuals who—

22 “(1) are not described in subsection
23 (a)(10)(A)(i);

24 “(2) have not attained age 65;

1 “(3) have been screened for breast and cervical
 2 cancer under the Centers for Disease Control and
 3 Prevention breast and cervical cancer early detection
 4 program established under title XV of the Public
 5 Health Service Act (42 U.S.C. 300k et seq.) in ac-
 6 cordance with the requirements of section 1504 of
 7 that Act (42 U.S.C. 300n) and need treatment for
 8 breast or cervical cancer; and

9 “(4) are not otherwise covered under creditable
 10 coverage, as defined in section 2701(c) of the Public
 11 Health Service Act (42 U.S.C. 300gg(c)).”.

12 (3) LIMITATION ON BENEFITS.—Section
 13 1902(a)(10) (42 U.S.C. 1396a(a)(10)) is amended
 14 in the matter following subparagraph (G)—

15 (A) by striking “and (XIII)” and inserting
 16 “(XIII)”; and

17 (B) by inserting “, and (XIV) the medical
 18 assistance made available to an individual de-
 19 scribed in subsection (aa) who is eligible for
 20 medical assistance only because of subpara-
 21 graph (A)(10)(ii)(XVIII) shall be limited to
 22 medical assistance provided during the period in
 23 which such an individual requires treatment for
 24 breast or cervical cancer” before the semicolon.

1 (4) CONFORMING AMENDMENTS.—Section
2 1905(a) (42 U.S.C. 1396d(a)) is amended in the
3 matter preceding paragraph (1)—

4 (A) in clause (xi), by striking “or” at the
5 end;

6 (B) in clause (xii), by adding “or” at the
7 end; and

8 (C) by inserting after clause (xii) the fol-
9 lowing:

10 “(xiii) individuals described in section
11 1902(aa),”.

12 (b) PRESUMPTIVE ELIGIBILITY.—

13 (1) IN GENERAL.—Title XIX (42 U.S.C. 1396
14 et seq.) is amended by inserting after section 1920A
15 the following:

16 “PRESUMPTIVE ELIGIBILITY FOR CERTAIN BREAST OR
17 CERVICAL CANCER PATIENTS

18 “SEC. 1920B. (a) STATE OPTION.—A State plan ap-
19 proved under section 1902 may provide for making med-
20 ical assistance available to an individual described in sec-
21 tion 1902(aa) (relating to certain breast or cervical cancer
22 patients) during a presumptive eligibility period.

23 “(b) DEFINITIONS.—For purposes of this section:

24 “(1) PRESUMPTIVE ELIGIBILITY PERIOD.—The
25 term ‘presumptive eligibility period’ means, with re-

1 spect to an individual described in subsection (a),
2 the period that—

3 “(A) begins with the date on which a
4 qualified entity determines, on the basis of pre-
5 liminary information, that the individual is de-
6 scribed in section 1902(aa); and

7 “(B) ends with (and includes) the earlier
8 of—

9 “(i) the day on which a determination
10 is made with respect to the eligibility of
11 such individual for services under the State
12 plan; or

13 “(ii) in the case of such an individual
14 who does not file an application by the last
15 day of the month following the month dur-
16 ing which the entity makes the determina-
17 tion referred to in subparagraph (A), such
18 last day.

19 “(2) QUALIFIED ENTITY.—

20 “(A) IN GENERAL.—Subject to subpara-
21 graph (B), the term ‘qualified entity’ means
22 any entity that—

23 “(i) is eligible for payments under a
24 State plan approved under this title; and

1 “(ii) is determined by the State agen-
 2 cy to be capable of making determinations
 3 of the type described in paragraph (1)(A).

4 “(B) REGULATIONS.—The Secretary may
 5 issue regulations further limiting those entities
 6 that may become qualified entities in order to
 7 prevent fraud and abuse and for other reasons.

8 “(C) RULE OF CONSTRUCTION.—Nothing
 9 in this paragraph shall be construed as pre-
 10 venting a State from limiting the classes of en-
 11 tities that may become qualified entities, con-
 12 sistent with any limitations imposed under sub-
 13 paragraph (B).

14 “(c) ADMINISTRATION.—

15 “(1) IN GENERAL.—The State agency shall pro-
 16 vide qualified entities with—

17 “(A) such forms as are necessary for an
 18 application to be made by an individual de-
 19 scribed in subsection (a) for medical assistance
 20 under the State plan; and

21 “(B) information on how to assist such in-
 22 dividuals in completing and filing such forms.

23 “(2) NOTIFICATION REQUIREMENTS.—A quali-
 24 fied entity that determines under subsection
 25 (b)(1)(A) that an individual described in subsection

1 (a) is presumptively eligible for medical assistance
2 under a State plan shall—

3 “(A) notify the State agency of the deter-
4 mination within 5 working days after the date
5 on which the determination is made; and

6 “(B) inform such individual at the time
7 the determination is made that an application
8 for medical assistance under the State plan is
9 required to be made by not later than the last
10 day of the month following the month during
11 which the determination is made.

12 “(3) APPLICATION FOR MEDICAL ASSIST-
13 ANCE.—In the case of an individual described in
14 subsection (a) who is determined by a qualified enti-
15 ty to be presumptively eligible for medical assistance
16 under a State plan, the individual shall apply for
17 medical assistance under such plan by not later than
18 the last day of the month following the month dur-
19 ing which the determination is made.

20 “(d) PAYMENT.—Notwithstanding any other provi-
21 sion of this title, medical assistance that—

22 “(1) is furnished to an individual described in
23 subsection (a)—

24 “(A) during a presumptive eligibility pe-
25 riod; and

1 “(B) by a entity that is eligible for pay-
2 ments under the State plan; and
3 “(2) is included in the care and services covered
4 by the State plan,
5 shall be treated as medical assistance provided by such
6 plan for purposes of clause (4) of the first sentence of
7 section 1905(b).”.

8 (2) CONFORMING AMENDMENTS.—

9 (A) Section 1902(a)(47) (42 U.S.C.
10 1396a(a)(47)) is amended by inserting before
11 the semicolon at the end the following: “and
12 provide for making medical assistance available
13 to individuals described in subsection (a) of sec-
14 tion 1920B during a presumptive eligibility pe-
15 riod in accordance with such section”.

16 (B) Section 1903(u)(1)(D)(v) (42 U.S.C.
17 1396b(u)(1)(D)(v)) is amended—

18 (i) by striking “or for” and inserting
19 “ , for”; and

20 (ii) by inserting before the period the
21 following: “ , or for medical assistance pro-
22 vided to an individual described in sub-
23 section (a) of section 1920B during a pre-
24 sumptive eligibility period under such sec-
25 tion”.

1 (c) ENHANCED MATCH.—The first sentence of sec-
 2 tion 1905(b) (42 U.S.C. 1396d(b)) is amended—

3 (1) by striking “and” before “(3)”; and

4 (2) by inserting before the period at the end the
 5 following: “, and (4) the Federal medical assistance
 6 percentage shall be equal to the enhanced FMAP de-
 7 scribed in section 2105(b) with respect to medical
 8 assistance provided to individuals who are eligible
 9 for such assistance only on the basis of section
 10 1902(a)(10)(A)(ii)(XVIII)”.

11 (d) EFFECTIVE DATE.—The amendments made by
 12 this section apply to medical assistance for items and serv-
 13 ices furnished on or after October 1, 2000, without regard
 14 to whether final regulations to carry out such amendments
 15 have been promulgated by such date.

16 **SEC. 708. MEDICAID COVERAGE OF SERVICES FURNISHED**
 17 **BY CERTIFIED NURSE PRACTITIONERS AND**
 18 **CLINICAL NURSE SPECIALISTS.**

19 (a) IN GENERAL.—Section 1905(a)(21) (42 U.S.C.
 20 1396d(a)(21)) is amended to read as follows:

21 “(21) services furnished by a certified nurse
 22 practitioner (as defined by the Secretary) or a clin-
 23 ical nurse specialist (as defined in subsection (x)
 24 which the certified nurse practitioner or clinical
 25 nurse specialist is legally authorized to perform

1 under State law (or the State regulatory mechanism
 2 provided by State law), whether or not the certified
 3 nurse practitioner or clinical nurse specialist is
 4 under the supervision of, or associated with, a physi-
 5 cian or other health care provider;”.

6 (b) DEFINITION OF CLINICAL NURSE SPECIALIST.—
 7 Section 1905 of such Act (42 U.S.C. 1396d) is amended
 8 by adding at the end the following new subsection:

9 “(x) The term ‘clinical nurse specialist’ means an in-
 10 dividual who has earned a master’s degree in a clinical
 11 area of nursing from an accredited institution and who
 12 is a registered nurse licensed to practice nursing in the
 13 State in which the individual furnishes services.”.

14 (c) EFFECTIVE DATE.—The amendments made by
 15 subsections (a) and (b) apply to calendar quarters begin-
 16 ning on or after October 1, 2000, without regard to wheth-
 17 er or not final regulations to carry out such amendments
 18 have been promulgated by such date.

19 **TITLE VIII—OTHER PROVISIONS**

20 **SEC. 801. APPROPRIATIONS FOR RICKY RAY HEMOPHILIA** 21 **RELIEF FUND.**

22 Section 101(e) of the Ricky Ray Hemophilia Relief
 23 Fund Act of 1998 (42 U.S.C. 300e–22 note) is amended
 24 by adding at the end the following: “There is appropriated

1 to the Fund \$475,000,000 for fiscal year 2001, to remain
2 available until expended.”.

3 **SEC. 802. INCREASE IN APPROPRIATIONS FOR SPECIAL DI-**
4 **ABETES PROGRAMS FOR CHILDREN WITH**
5 **TYPE I DIABETES AND INDIANS.**

6 (a) SPECIAL DIABETES PROGRAMS FOR CHILDREN
7 WITH TYPE I DIABETES.—Section 330B(b) of the Public
8 Health Service Act (42 U.S.C. 254c–2(b)) is amended—

9 (1) by striking “Notwithstanding” and insert-
10 ing the following:

11 “(1) TRANSFERRED FUNDS.—Notwith-
12 standing”; and

13 (2) by adding at the end the following:

14 “(2) APPROPRIATIONS.—For the purpose of
15 making grants under this section, there are appro-
16 priated, out of any money in the Treasury not other-
17 wise appropriated—

18 “(A) \$70,000,000 for each of fiscal years
19 2001 and 2002 (which shall be combined with
20 amounts transferred under paragraph (1) for
21 each such fiscal years); and

22 “(B) \$100,000,000 for each of fiscal years
23 2003 through 2005.”.

1 (b) SPECIAL DIABETES PROGRAMS FOR INDIANS.—
 2 Section 330C(c) of the Public Health Service Act (42
 3 U.S.C. 254c-3(c)) is amended—

4 (1) by striking “Notwithstanding” and insert-
 5 ing the following:

6 “(1) TRANSFERRED FUNDS.—Notwith-
 7 standing”;

8 (2) by adding at the end the following:

9 “(2) APPROPRIATIONS.—For the purpose of
 10 making grants under this section, there are appro-
 11 priated, out of any money in the Treasury not other-
 12 wise appropriated—

13 “(A) \$70,000,000 for each of fiscal years
 14 2001 and 2002 (which shall be combined with
 15 amounts transferred under paragraph (1) for
 16 each such fiscal years); and

17 “(B) \$100,000,000 for each of fiscal years
 18 2003 through 2005.”.

19 **SEC. 803. DEMONSTRATION GRANTS TO IMPROVE OUT-**
 20 **REACH, ENROLLMENT, AND COORDINATION**
 21 **OF PROGRAMS AND SERVICES TO HOMELESS**
 22 **INDIVIDUALS AND FAMILIES.**

23 (a) AUTHORITY.—The Secretary of Health and
 24 Human Services may award demonstration grants to not
 25 more than 7 States (or other qualified entities) to conduct

1 innovative programs that are designed to improve out-
2 reach to homeless individuals and families under the pro-
3 grams described in subsection (b) with respect to enroll-
4 ment of such individuals and families under such pro-
5 grams and the provision of services (and coordinating the
6 provision of such services) under such programs.

7 (b) PROGRAMS FOR HOMELESS DESCRIBED.—The
8 programs described in this subsection are as follows:

9 (1) MEDICAID.—The program under title XIX
10 of the Social Security Act (42 U.S.C. 1396 et seq.).

11 (2) SCHIP.—The program under title XXI of
12 such Act (42 U.S.C. 1397aa et seq.).

13 (3) TANF.—The program under part of A of
14 title IV of such Act (42 U.S.C. 601 et seq.).

15 (4) MATERNAL AND CHILD HEALTH BLOCK
16 GRANTS.—The program under title V of the Social
17 Security Act (42 U.S.C. 701 et seq.).

18 (5) MENTAL HEALTH AND SUBSTANCE ABUSE
19 BLOCK GRANTS.—The program under part B of title
20 XIX of the Public Health Service Act (42 U.S.C.
21 300x–1 et seq.).

22 (6) HIV/AIDS CARE GRANTS.—The program
23 under part B of title XXVI of the Public Health
24 Service Act (42 U.S.C. 300ff–21 et seq.).

1 (7) FOOD STAMP PROGRAM.—The program
2 under the Food Stamp Act of 1977 (7 U.S.C. 2011
3 et seq.).

4 (8) WORKFORCE INVESTMENT ACT.—The pro-
5 gram under the Workforce Investment Act of 1999
6 (29 U.S.C. 2801 et seq.).

7 (9) WELFARE-TO-WORK.—The welfare-to-work
8 program under section 403(a)(5) of the Social Secu-
9 rity Act (42 U.S.C. 603(a)(5)).

10 (10) OTHER PROGRAMS.—Other public and pri-
11 vate benefit programs that serve low-income individ-
12 uals.

13 (c) APPROPRIATIONS.—For the purposes of carrying
14 out this section, there are appropriated, out of any funds
15 in the Treasury not otherwise appropriated, \$10,000,000,
16 to remain available until expended.

17 **SEC. 804. PROTECTION OF AN HMO ENROLLEE TO RECEIVE**
18 **CONTINUING CARE AT A FACILITY SELECTED**
19 **BY THE ENROLLEE.**

20 (a) AMENDMENTS TO THE EMPLOYEE RETIREMENT
21 INCOME SECURITY ACT OF 1974.—

22 (1) IN GENERAL.—Subpart B of part 7 of sub-
23 title B of title I of the Employee Retirement Income
24 Security Act of 1974 (29 U.S.C. 1185 et seq.) is

1 amended by adding at the end the following new sec-
2 tion:

3 **“SEC. 714. ENSURING CHOICE FOR CONTINUING CARE.**

4 “(a) IN GENERAL.—With respect to health insurance
5 coverage provided to participants or beneficiaries through
6 a managed care organization under a group health plan,
7 or through a health insurance issuer providing health in-
8 surance coverage in connection with a group health plan,
9 such plan or issuer may not deny coverage for services
10 provided to such participant or beneficiary by a continuing
11 care retirement community, skilled nursing facility, or
12 other qualified facility in which the participant or bene-
13 ficiary resided prior to a hospitalization, regardless of
14 whether such organization is under contract with such
15 community or facility if the requirements described in sub-
16 section (b) are met.

17 “(b) REQUIREMENTS.—The requirements of this sub-
18 section are that—

19 “(1) the service involved is a service for which
20 the managed care organization involved would be re-
21 quired to provide or pay for under its contract with
22 the participant or beneficiary if the continuing care
23 retirement community, skilled nursing facility, or
24 other qualified facility were under contract with the
25 organization;

1 “(2) the participant or beneficiary involved—

2 “(A) resided in the continuing care retire-
3 ment community, skilled nursing facility, or
4 other qualified facility prior to being hospital-
5 ized;

6 “(B) had a contractual or other right to
7 return to the facility after hospitalization; and

8 “(C) elects to return to the facility after
9 hospitalization, whether or not the residence of
10 the participant or beneficiary after returning
11 from the hospital is the same part of the facility
12 in which the beneficiary resided prior to hos-
13 pitalization;

14 “(3) the continuing care retirement community,
15 skilled nursing facility, or other qualified facility has
16 the capacity to provide the services the participant
17 or beneficiary needs; and

18 “(4) the continuing care retirement community,
19 skilled nursing facility, or other qualified facility is
20 willing to accept substantially similar payment under
21 the same terms and conditions that apply to simi-
22 larly situated health care facility providers under
23 contract with the organization involved.

24 “(c) SERVICES TO PREVENT HOSPITALIZATION.—A
25 group health plan or health insurance issuer to which this

1 section applies may not deny payment for a skilled nursing
2 service provided to a participant or beneficiary by a con-
3 tinuing care retirement community, skilled nursing facil-
4 ity, or other qualified facility in which the participant or
5 beneficiary resides, without a preceding hospital stay, re-
6 gardless of whether the organization is under contract
7 with such community or facility, if—

8 “(1) the plan or issuer has determined that the
9 service is necessary to prevent the hospitalization of
10 the participant or beneficiary; and

11 “(2) the service to prevent hospitalization is
12 provided as an additional benefit as described in sec-
13 tion 417.594 of title 42, Code of Federal Regula-
14 tions, and would otherwise be covered as provided
15 for in subsection (b)(1).

16 “(d) RIGHTS OF SPOUSES.—A group health plan or
17 health insurance issuer to which this section applies shall
18 not deny payment for services provided by a skilled nurs-
19 ing facility for the care of a participant or beneficiary, re-
20 gardless of whether the plan or issuer is under contract
21 with such facility, if the spouse of the participant or bene-
22 ficiary is already a resident of such facility and the re-
23 quirements described in subsection (b) are met.

24 “(e) EXCEPTIONS.—Subsection (a) shall not apply—

1 “(1) where the attending acute care provider
2 and the participant or beneficiary (or a designated
3 representative of the participant or beneficiary where
4 the participant or beneficiary is physically or men-
5 tally incapable of making an election under this
6 paragraph) do not elect to pursue a course of treat-
7 ment necessitating continuing care; or

8 “(2) unless the community or facility involved—

9 “(A) meets all applicable licensing and cer-
10 tification requirements of the State in which it
11 is located; and

12 “(B) agrees to reimbursement for the care
13 of the participant or beneficiary at a rate simi-
14 lar to the rate negotiated by the managed care
15 organization with similar providers of care for
16 similar services.

17 “(f) PROHIBITIONS.—A group health plan and a
18 health insurance issuer providing health insurance cov-
19 erage in connection with a group health plan may not—

20 “(1) deny to an individual eligibility, or contin-
21 ued eligibility, to enroll or to renew coverage with a
22 managed care organization under the plan, solely for
23 the purpose of avoiding the requirements of this sec-
24 tion;

1 “(2) provide monetary payments or rebates to
2 enrollees to encourage such enrollees to accept less
3 than the minimum protections available under this
4 section;

5 “(3) penalize or otherwise reduce or limit the
6 reimbursement of an attending physician because
7 such physician provided care to a participant or ben-
8 eficiary in accordance with this section; or

9 “(4) provide incentives (monetary or otherwise)
10 to an attending physician to induce such physician
11 to provide care to a participant or beneficiary in a
12 manner inconsistent with this section.

13 “(g) RULES OF CONSTRUCTION.—

14 “(1) HMO NOT OFFERING BENEFITS.—This
15 section shall not apply with respect to any managed
16 care organization under a group health plan, or
17 through a health insurance issuer providing health
18 insurance coverage in connection with a group health
19 plan, that does not provide benefits for stays in a
20 continuing care retirement community, skilled nurs-
21 ing facility, or other qualified facility.

22 “(2) COST-SHARING.—Nothing in this section
23 shall be construed as preventing a managed care or-
24 ganization under a group health plan, or through a
25 health insurance issuer providing health insurance

1 coverage in connection with a group health plan,
2 from imposing deductibles, coinsurance, or other
3 cost-sharing in relation to benefits for care in a con-
4 tinuing care facility.

5 “(h) PREEMPTION; EXCEPTION FOR HEALTH INSUR-
6 ANCE COVERAGE IN CERTAIN STATES.—

7 “(1) IN GENERAL.—The requirements of this
8 section shall not apply with respect to health insur-
9 ance coverage to the extent that a State law (as de-
10 fined in section 2723(d)(1) of the Public Health
11 Service Act) applies to such coverage and is de-
12 scribed in any of the following subparagraphs:

13 “(A) Such State law requires such cov-
14 erage to provide for referral to a continuing
15 care retirement community, skilled nursing fa-
16 cility, or other qualified facility in a manner
17 that is more protective of participants or bene-
18 ficiaries than the provisions of this section.

19 “(B) Such State law expands the range of
20 services or facilities covered under this section
21 and is otherwise more protective of the rights of
22 participants or beneficiaries than the provisions
23 of this section.

24 “(2) CONSTRUCTION.—Section 731(a)(1) shall
25 not be construed to provide that any requirement of

1 this section applies with respect to health insurance
2 coverage, to the extent that a State law described
3 in paragraph (1) applies to such coverage.

4 “(i) PENALTIES.—A participant or beneficiary may
5 enforce the provisions of this section in an appropriate
6 Federal district court. An action for injunctive relief or
7 damages may be commenced on behalf of the participant
8 or beneficiary by the participant’s or beneficiary’s legal
9 representative. The court may award reasonable attorneys’
10 fees to the prevailing party. If a beneficiary dies before
11 conclusion of an action under this section, the action may
12 be maintained by a representative of the participant’s or
13 beneficiary’s estate.

14 “(j) DEFINITIONS.—In this section:

15 “(1) ATTENDING ACUTE CARE PROVIDER.—The
16 term ‘attending acute care provider’ means anyone
17 licensed or certified under State law to provide
18 health care services who is operating within the
19 scope of such license and who is primarily respon-
20 sible for the care of the enrollee.

21 “(2) CONTINUING CARE RETIREMENT COMMU-
22 NITY.—The term ‘continuing care retirement com-
23 munity’ means an organization that provides or ar-
24 ranges for the provision of housing and health-re-
25 lated services to an older person under an agreement

1 effective for the life of the person or for a specified
2 period greater than 1 year.

3 “(3) MANAGED CARE ORGANIZATION.—The
4 term ‘managed care organization’ means an organi-
5 zation that provides comprehensive health services to
6 participants or beneficiaries, directly or under con-
7 tract or other agreement, on a prepayment basis to
8 such individuals. For purposes of this section, the
9 following shall be considered as managed care orga-
10 nizations:

11 “(A) A Medicare+Choice plan authorized
12 under section 1851(a) of the Social Security
13 Act (42 U.S.C. 1395w–21(a)).

14 “(B) Any other entity that manages the
15 cost, utilization, and delivery of health care
16 through the use of predetermined periodic pay-
17 ments to health care providers employed by or
18 under contract or other agreement, directly or
19 indirectly, with the entity.

20 “(4) OTHER QUALIFIED FACILITY.—The term
21 ‘other qualified facility’ means any facility that can
22 provide the services required by the participant or
23 beneficiary consistent with State and Federal law.

24 “(5) SKILLED NURSING FACILITY.—The term
25 ‘skilled nursing facility’ means a facility that meets

1 the requirements of section 1819 of the Social Secu-
 2 rity Act (42 U.S.C. 1395i-3).”.

3 (2) CLERICAL AMENDMENT.—The table of con-
 4 tents in section 1 of the Employee Retirement In-
 5 come Security Act of 1974 is amended by inserting
 6 after the items relating to subpart B of part 7 of
 7 subtitle B of title I the following new item:

“Sec. 714. Ensuring choice for continuing care.”.

8 (3) EFFECTIVE DATE.—The amendments made
 9 by this section shall apply with respect to plan years
 10 beginning on or after January 1, 2001.

11 (b) AMENDMENT TO THE PUBLIC HEALTH SERVICE
 12 ACT RELATING TO THE GROUP MARKET.—

13 (1) IN GENERAL.—Subpart 2 of part A of title
 14 XXVII of the Public Health Service Act (42 U.S.C.
 15 300gg-4 et seq.) is amended by adding at the end
 16 the following new section:

17 **“SEC. 2707. ENSURING CHOICE FOR CONTINUING CARE.**

18 “(a) IN GENERAL.—With respect to health insurance
 19 coverage provided to enrollees through a managed care or-
 20 ganization under a group health plan, or through a health
 21 insurance issuer providing health insurance coverage in
 22 connection with a group health plan, such plan or issuer
 23 may not deny coverage for services provided to such en-
 24 rollee by a continuing care retirement community, skilled
 25 nursing facility, or other qualified facility in which the en-

1 rollee resided prior to a hospitalization, regardless of
2 whether such organization is under contract with such
3 community or facility if the requirements described in sub-
4 section (b) are met.

5 “(b) REQUIREMENTS.—The requirements of this sub-
6 section are that—

7 “(1) the service involved is a service for which
8 the managed care organization involved would be re-
9 quired to provide or pay for under its contract with
10 the enrollee if the continuing care retirement com-
11 munity, skilled nursing facility, or other qualified fa-
12 cility were under contract with the organization;

13 “(2) the enrollee involved—

14 “(A) resided in the continuing care retire-
15 ment community, skilled nursing facility, or
16 other qualified facility prior to being hospital-
17 ized;

18 “(B) had a contractual or other right to
19 return to the facility after hospitalization; and

20 “(C) elects to return to the facility after
21 hospitalization, whether or not the residence of
22 the enrollee after returning from the hospital is
23 the same part of the facility in which the bene-
24 ficiary resided prior to hospitalization;

1 “(3) the continuing care retirement community,
2 skilled nursing facility, or other qualified facility has
3 the capacity to provide the services the enrollee
4 needs; and

5 “(4) the continuing care retirement community,
6 skilled nursing facility, or other qualified facility is
7 willing to accept substantially similar payment under
8 the same terms and conditions that apply to simi-
9 larly situated health care facility providers under
10 contract with the organization involved.

11 “(c) SERVICES TO PREVENT HOSPITALIZATION.—A
12 group health plan or health insurance issuer to which this
13 section applies may not deny payment for a skilled nursing
14 service provided to an enrollee by a continuing care retire-
15 ment community, skilled nursing facility, or other quali-
16 fied facility in which the enrollee resides, without a pre-
17 ceding hospital stay, regardless of whether the plan or
18 issuer is under contract with such community or facility,
19 if—

20 “(1) the plan or issuer has determined that the
21 service is necessary to prevent the hospitalization of
22 the enrollee; and

23 “(2) the service to prevent hospitalization is
24 provided as an additional benefit as described in sec-
25 tion 417.594 of title 42, Code of Federal Regula-

1 tions, and would be covered as provided for in sub-
2 section (b)(1).

3 “(d) RIGHTS OF SPOUSES.—A group health plan or
4 health insurance issuer to which this section applies shall
5 not deny payment for services provided by a skilled nurs-
6 ing facility for the care of an enrollee, regardless of wheth-
7 er the plan or issuer is under contract with such facility,
8 if the spouse of the enrollee is already a resident of such
9 facility and the requirements described in subsection (b)
10 are met.

11 “(e) EXCEPTIONS.—Subsection (a) shall not apply—

12 “(1) where the attending acute care provider
13 and the enrollee (or a designated representative of
14 the enrollee where the enrollee is physically or men-
15 tally incapable of making an election under this
16 paragraph) do not elect to pursue a course of treat-
17 ment necessitating continuing care; or

18 “(2) unless the community or facility involved—

19 “(A) meets all applicable licensing and cer-
20 tification requirements of the State in which it
21 is located; and

22 “(B) agrees to reimbursement for the care
23 of the enrollee at a rate similar to the rate ne-
24 gotiated by the managed care organization with
25 similar providers of care for similar services.

1 “(f) PROHIBITIONS.—A group health plan and a
2 health insurance issuer providing health insurance cov-
3 erage in connection with a group health plan may not—

4 “(1) deny to an individual eligibility, or contin-
5 ued eligibility, to enroll or to renew coverage with a
6 managed care organization under the plan, solely for
7 the purpose of avoiding the requirements of this sec-
8 tion;

9 “(2) provide monetary payments or rebates to
10 enrollees to encourage such enrollees to accept less
11 than the minimum protections available under this
12 section;

13 “(3) penalize or otherwise reduce or limit the
14 reimbursement of an attending physician because
15 such physician provided care to an enrollee in ac-
16 cordance with this section; or

17 “(4) provide incentives (monetary or otherwise)
18 to an attending physician to induce such physician
19 to provide care to an enrollee in a manner incon-
20 sistent with this section.

21 “(g) RULES OF CONSTRUCTION.—

22 “(1) HMO NOT OFFERING BENEFITS.—This
23 section shall not apply with respect to any managed
24 care organization under a group health plan, or
25 through a health insurance issuer providing health

1 insurance coverage in connection with a group health
2 plan, that does not provide benefits for stays in a
3 continuing care retirement community, skilled nurs-
4 ing facility, or other qualified facility.

5 “(2) COST-SHARING.—Nothing in this section
6 shall be construed as preventing a managed care or-
7 ganization under a group health plan, or through a
8 health insurance issuer providing health insurance
9 coverage in connection with a group health plan,
10 from imposing deductibles, coinsurance, or other
11 cost-sharing in relation to benefits for care in a con-
12 tinuing care facility.

13 “(h) PREEMPTION; EXCEPTION FOR HEALTH INSUR-
14 ANCE COVERAGE IN CERTAIN STATES.—

15 “(1) IN GENERAL.—The requirements of this
16 section shall not apply with respect to health insur-
17 ance coverage to the extent that a State law (as de-
18 fined in section 2723(d)(1)) applies to such coverage
19 and is described in any of the following subpara-
20 graphs:

21 “(A) Such State law requires such cov-
22 erage to provide for referral to a continuing
23 care retirement community, skilled nursing fa-
24 cility, or other qualified facility in a manner

1 that is more protective of the enrollee than the
2 provisions of this section.

3 “(B) Such State law expands the range of
4 services or facilities covered under this section
5 and is otherwise more protective of enrollee
6 rights than the provisions of this section.

7 “(2) CONSTRUCTION.—Section 2723(a)(1) shall
8 not be construed to provide that any requirement of
9 this section applies with respect to health insurance
10 coverage, to the extent that a State law described in
11 paragraph (1) applies to such coverage.

12 “(i) PENALTIES.—An enrollee may enforce the provi-
13 sions of this section in an appropriate Federal district
14 court. An action for injunctive relief or damages may be
15 commenced on behalf of the enrollee by the enrollee’s legal
16 representative. The court may award reasonable attorneys’
17 fees to the prevailing party. If a beneficiary dies before
18 conclusion of an action under this section, the action may
19 be maintained by a representative of the enrollee’s estate.

20 “(j) DEFINITIONS.—In this section:

21 “(1) ATTENDING ACUTE CARE PROVIDER.—The
22 term ‘attending acute care provider’ means anyone
23 licensed or certified under State law to provide
24 health care services who is operating within the

1 scope of such license and who is primarily respon-
2 sible for the care of the enrollee.

3 “(2) CONTINUING CARE RETIREMENT COMMU-
4 NITY.—The term ‘continuing care retirement com-
5 munity’ means an organization that provides or ar-
6 ranges for the provision of housing and health-re-
7 lated services to an older person under an agreement
8 effective for the life of the person or for a specified
9 period greater than 1 year.

10 “(3) MANAGED CARE ORGANIZATION.—The
11 term ‘managed care organization’ means an organi-
12 zation that provides comprehensive health services to
13 enrollees, directly or under contract or other agree-
14 ment, on a prepayment basis to such individuals.
15 For purposes of this section, the following shall be
16 considered as managed care organizations:

17 “(A) A Medicare+Choice plan authorized
18 under section 1851(a) of the Social Security
19 Act (42 U.S.C. 1395w–21(a)).

20 “(B) Any other entity that manages the
21 cost, utilization, and delivery of health care
22 through the use of predetermined periodic pay-
23 ments to health care providers employed by or
24 under contract or other agreement, directly or
25 indirectly, with the entity.

1 “(4) OTHER QUALIFIED FACILITY.—The term
2 ‘other qualified facility’ means any facility that can
3 provide the services required by the enrollee con-
4 sistent with State and Federal law.

5 “(5) SKILLED NURSING FACILITY.—The term
6 ‘skilled nursing facility’ means a facility that meets
7 the requirements of section 1819 of the Social Secu-
8 rity Act (42 U.S.C. 1395i–3).”.

9 (2) EFFECTIVE DATE.—The amendment made
10 by this section shall apply with respect to group
11 health plans for plan years beginning on or after
12 January 1, 2001.

13 (c) AMENDMENTS TO THE PUBLIC HEALTH SERVICE
14 ACT RELATING TO THE INDIVIDUAL MARKET.—

15 (1) IN GENERAL.—The first subpart 3 of part
16 B of title XXVII of the Public Health Service Act
17 (42 U.S.C. 300gg–51 et seq.) (relating to other re-
18 quirements) is amended—

19 (A) by redesignating such subpart as sub-
20 part 2; and

21 (B) by adding at the end the following new
22 section:

23 **“SEC. 2753. ENSURING CHOICE FOR CONTINUING CARE.**

24 “The provisions of section 2707 shall apply to health
25 maintenance organization coverage offered by a health in-

1 surance issuer in the individual market in the same man-
2 ner as they apply to such coverage offered by a health
3 insurance issuer in connection with a group health plan
4 in the small or large group market.”.

5 (2) EFFECTIVE DATE.—The amendment made
6 by this section shall apply with respect to health in-
7 surance coverage offered, sold, issued, renewed, in
8 effect, or operated in the individual market on or
9 after January 1, 2001.

10 **SEC. 805. GRANTS TO DEVELOP AND ESTABLISH REAL**
11 **CHOICE SYSTEMS CHANGE INITIATIVES.**

12 (a) ESTABLISHMENT.—

13 (1) IN GENERAL.—The Secretary of Health and
14 Human Services (in this section referred to as the
15 “Secretary”) shall award grants described in sub-
16 section (b) to States to support real choice systems
17 change initiatives that establish specific action steps
18 and specific timetables to achieve enduring system
19 improvements and to provide consumer-responsive
20 long-term services and supports to eligible individ-
21 uals in the most integrated setting appropriate based
22 on the unique strengths and needs of the individual,
23 the priorities and concerns of the individual (or, as
24 appropriate, the individual’s representative), and the

1 individual's desires with regard to participation in
2 community life.

3 (2) ELIGIBILITY.—To be eligible for a grant
4 under this section, a State shall—

5 (A) establish a Consumer Task Force in
6 accordance with subsection (d); and

7 (B) submit an application at such time, in
8 such manner, and containing such information
9 as the Secretary may determine. The applica-
10 tion shall be jointly developed and signed by the
11 designated State official and the chairperson of
12 such Task Force, acting on behalf of and at the
13 direction of the Task Force.

14 (3) DEFINITION OF STATE.—In this section,
15 the term “State” means each of the 50 States, the
16 District of Columbia, Puerto Rico, Guam, the
17 United States Virgin Islands, American Samoa, and
18 the Commonwealth of the Northern Mariana Is-
19 lands.

20 (b) GRANTS FOR REAL CHOICE SYSTEMS CHANGE
21 INITIATIVES.—

22 (1) IN GENERAL.—From funds appropriated
23 under subsection (f), the Secretary shall award
24 grants to States to—

1 (A) support the establishment, implemen-
2 tation, and operation of the State real choice
3 systems change initiatives described in sub-
4 section (a); and

5 (B) conduct outreach campaigns regarding
6 the existence of such initiatives.

7 (2) DETERMINATION OF AWARDS; STATE AL-
8 LOTMENTS.—The Secretary shall develop a formula
9 for the distribution of funds to States for each fiscal
10 year under subsection (a). Such formula shall give
11 preference to States that have a higher need for as-
12 sistance, as determined by the Secretary, based on
13 indicators such as a relatively higher proportion of
14 long-term services and supports furnished to individ-
15 uals in an institutional setting but who have a plan
16 described in an application submitted under sub-
17 section (a)(2).

18 (c) AUTHORIZED ACTIVITIES.—A State that receives
19 a grant under this section shall use the funds made avail-
20 able through the grant to accomplish the purposes de-
21 scribed in subsection (a) and, in accomplishing such pur-
22 poses, may carry out any of the following systems change
23 activities:

24 (1) NEEDS ASSESSMENT AND DATA GATH-
25 ERING.—The State may use funds to conduct a

1 statewide needs assessment that may be based on
2 data in existence on the date on which the assess-
3 ment is initiated and may include information about
4 the number of individuals within the State who are
5 receiving long-term services and supports in unnec-
6 essarily segregated settings, the nature and extent to
7 which current programs respond to the preferences
8 of individuals with disabilities to receive services in
9 home and community-based settings as well as in in-
10 stitutional settings, and the expected change in de-
11 mand for services provided in home and community
12 settings as well as institutional settings.

13 (2) INSTITUTIONAL BIAS: REMEDIES AND PRO-
14 MOTION OF COMMUNITY PARTICIPATION.—The State
15 may use funds to identify, develop, and implement
16 strategies for modifying policies, practices, and pro-
17 cedures that unnecessarily bias the provision of long-
18 term services and supports toward institutional set-
19 tings and away from home and community-based
20 settings, including policies, practices, and procedures
21 governing statewideness, comparability in amount,
22 duration, and scope of services, financial eligibility,
23 individualized functional assessments and screenings
24 (including individual and family involvement), knowl-
25 edge about service options, and promotion of self-di-

1 rection of services and community-integrated living
2 and service arrangements that facilitate participa-
3 tion in community life to the fullest extent possible
4 and desired by the individual.

5 (3) OVER MEDICALIZATION OF SERVICES.—The
6 State may use funds to identify, develop, and imple-
7 ment strategies for modifying policies, practices, and
8 procedures that unnecessarily bias the provision of
9 long-term services and supports by health care pro-
10 fessionals to the extent that quality services and
11 supports can be provided by other qualified individ-
12 uals, including policies, practices, and procedures
13 governing service authorization, case management,
14 and service coordination, service delivery options,
15 quality controls, and supervision and training.

16 (4) INTERAGENCY COORDINATION; SINGLE
17 POINT OF ENTRY.—The State may support activities
18 to identify and coordinate Federal and State poli-
19 cies, resources, and services, relating to the provision
20 of long-term services and supports, including the
21 convening of interagency work groups and the enter-
22 ing into of interagency agreements that provide for
23 a single point of entry with one-stop access for long-
24 term support services and the design and implemen-
25 tation of a coordinated screening and assessment

1 system for all persons eligible for long-term services
2 and supports.

3 (5) TRAINING AND TECHNICAL ASSISTANCE.—

4 The State may carry out directly, or may provide
5 support to a public or private entity to carry out
6 training and technical assistance activities that are
7 provided for individuals with disabilities, and, as ap-
8 propriate, their representatives, attendants, and
9 other personnel (including professionals, paraprofes-
10 sionals, volunteers, and other members of the com-
11 munity).

12 (6) PUBLIC AWARENESS.—The State may sup-
13 port a public awareness program that is designed to
14 provide information relating to the availability of
15 choices available to individuals with disabilities for
16 receiving long-term services and support in the most
17 integrated setting appropriate.

18 (7) TRANSITIONAL COSTS.—The State may use
19 funds to provide transitional costs such as rent and
20 utility deposits, first months's rent and utilities, bed-
21 ding, basic kitchen supplies, and other necessities re-
22 quired for an individual to make the transition from
23 an institutional facility to a community-based home
24 setting where the individual resides.

1 (8) TASK FORCE.—The State may use funds to
2 support the operation of the Consumer Task Force
3 established under subsection (d).

4 (9) DEMONSTRATIONS OF NEW APPROACHES.—
5 The State may use funds to conduct, on a time-lim-
6 ited basis, the demonstration of new approaches to
7 accomplishing the purposes described in subsection
8 (a)(1).

9 (10) IMPROVEMENT IN THE QUALITY OF SERV-
10 ICES AND SUPPORTS.—The State may use funds to
11 improve the quality of services and supports pro-
12 vided to individuals with disabilities and their fami-
13 lies.

14 (11) OTHER ACTIVITIES.—The State may use
15 funds for any systems change activities that are not
16 described in any of the preceding paragraphs of this
17 subsection and that are necessary for developing, im-
18 plementing, or evaluating the comprehensive state-
19 wide system of community-integrated long-term serv-
20 ices and supports.

21 (d) CONSUMER TASK FORCE.—

22 (1) ESTABLISHMENT AND DUTIES.—To be eli-
23 gible to receive a grant under this section, each
24 State shall establish a Consumer Task Force (re-
25 ferred to in this section as the “Task Force”) to as-

1 sist the State in the development, implementation,
2 and evaluation of real choice systems change initia-
3 tives.

4 (2) APPOINTMENT.—Members of the Task
5 Force shall be appointed by the Chief Executive Of-
6 ficer of the State in accordance with the require-
7 ments of paragraph (3), after the solicitation of rec-
8 ommendations from representatives of organizations
9 representing a broad range of individuals with dis-
10 abilities and organizations interested in individuals
11 with disabilities.

12 (3) COMPOSITION.—

13 (A) IN GENERAL.—The Task Force shall
14 represent a broad range of individuals with dis-
15 abilities from diverse backgrounds and shall in-
16 clude representatives from Developmental Dis-
17 abilities Councils, Mental Health Councils,
18 State Independent Living Centers and Councils,
19 Commissions on Aging, organizations that pro-
20 vide services to individuals with disabilities and
21 consumers of long-term services and supports.

22 (B) INDIVIDUALS WITH DISABILITIES.—A
23 majority of the members of the Task Force
24 shall be individuals with disabilities or the rep-
25 resentatives of such individuals.

1 (C) LIMITATION.—The Task Force shall
2 not include employees of any State agency pro-
3 viding services to individuals with disabilities
4 other than employees of agencies described in
5 the Developmental Disabilities Assistance and
6 Bill of Rights Act (42 U.S.C. 6000 et seq.) or
7 the Protection and Advocacy for Mentally Ill
8 Individuals Act of 1986 (42 U.S.C. 10801 et
9 seq.).

10 (e) AVAILABILITY OF FUNDS.—

11 (1) FUNDS ALLOTTED TO STATES.—Funds al-
12 lotted to a State under a grant made under this sec-
13 tion for a fiscal year shall remain available until ex-
14 pended.

15 (2) FUNDS NOT ALLOTTED TO STATES.—Funds
16 not allotted to States in the fiscal year for which
17 they are appropriated shall remain available in suc-
18 ceeding fiscal years for allotment by the Secretary
19 using the allotment formula established by the Sec-
20 retary under subsection (b)(2).

21 (f) ANNUAL REPORT.—A State that receives a grant
22 under this section shall submit an annual report to the
23 Secretary on the use of funds provided under the grant.
24 Each report shall include the number and percentage in-
25 crease in the number of eligible individuals in the State

1 who receive long-term services and supports in the most
2 integrated setting appropriate, including through commu-
3 nity attendant services and supports and other commu-
4 nity-based settings.

5 (g) FUNDING.—

6 (1) FISCAL YEAR 2001.—For the purpose of
7 making grants under this section, there are appro-
8 priated, out of any funds in the Treasury not other-
9 wise appropriated, \$50,000,000 for fiscal year 2001.

10 (2) FISCAL YEAR 2002 AND THEREAFTER.—

11 There is authorized to be appropriated such sums as
12 may be necessary to carry out this section for fiscal
13 year 2002 and each fiscal year thereafter.

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